Provider Manual

Molina Healthcare of Ohio, Inc.

(Molina Healthcare or Molina)

2019 Molina Marketplace Product*
Effective January 1, 2019

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

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1. Contact Information for Providers

Provider Services Department

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

Provider Services	
Address:	Molina Healthcare of 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 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 AlertLine or submit an electronic complaint using the website listed below. For more information about fraud, waste and abuse, please see the Compliance section of this Provider Manual.

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

Credentialing Department

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

The Healthcare Services 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 twenty-four/seven (24/7) online submission and status checks.
- Ensures HIPAA compliance.
- Ability to receive real-time authorization status.
- Ability to upload medical records.
- Increased efficiencies through reduced telephonic interactions.
- Reduces cost associated with fax and telephonic interactions.

Molina offers the following electronic prior authorizations/service requests submission options:

- Submit requests directly to Molina via the Provider Portal. See the Provider Portal Quick Reference Guide on our website at www.MolinaHealthcare.com 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:	(866) 472-9483
Fax:	(562) 901-1176
Health Management Programs	
Phone:	(866) 891-2320
Fax:	(800) 642-3691

Behavioral Health

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

Behavioral Health	
Address:	Molina Healthcare of 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/TDD:	711

Pharmacy Department

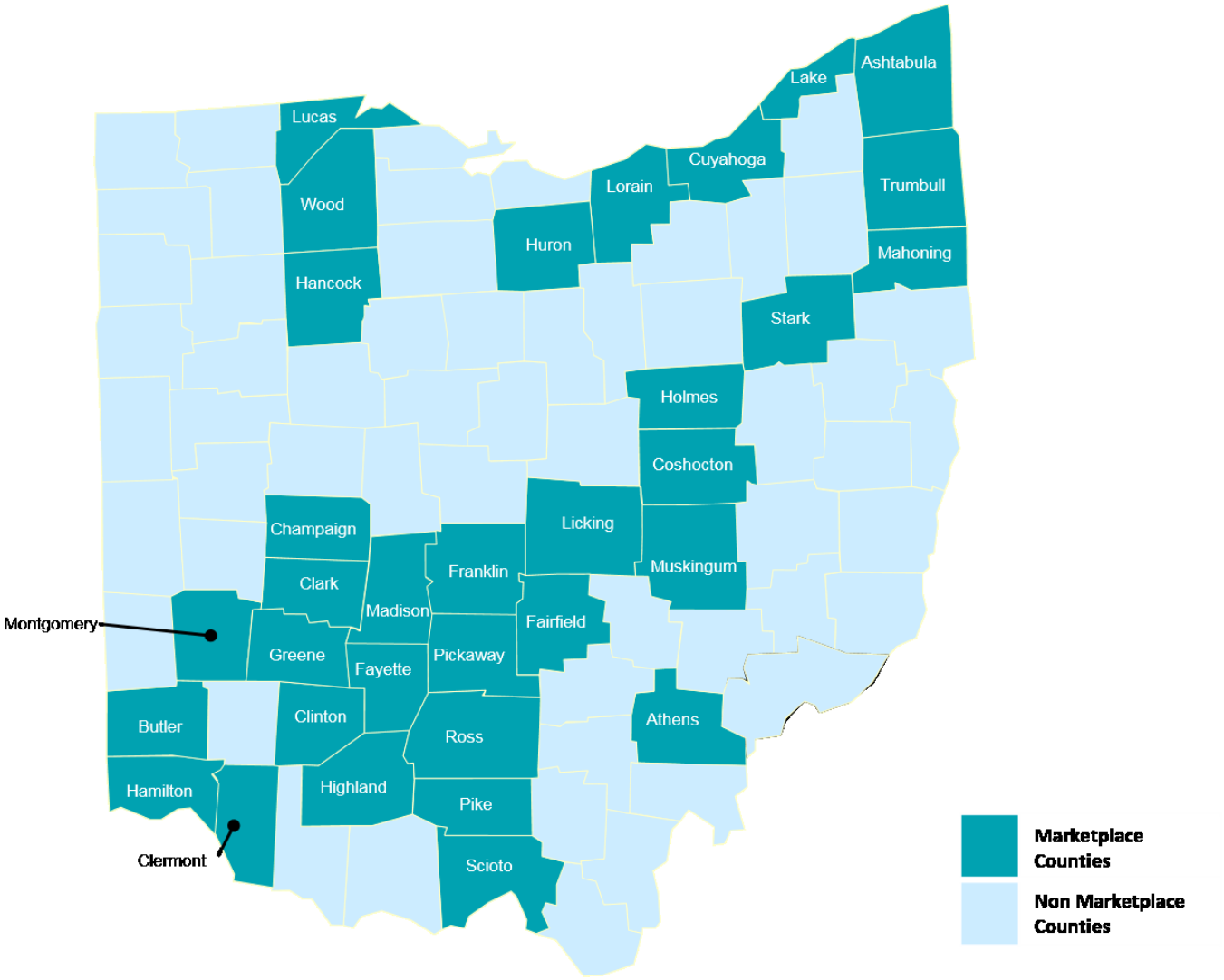
Prescription drugs are covered by Molina, via our pharmacy vendor, CVS Caremark. A list of in-network pharmacies is available on the www.MolinaHealthcare.com website, or by contacting Molina at (855) 322-4079.

Quality

Molina maintains a Quality department to work with members and providers in administering Molina's Quality Programs.

Quality	
Phone:	(888) 296-7677

Molina Service Area



2. Provider Responsibilities

Nondiscrimination of Health Care Service Delivery

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

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

Section 1557 Investigations

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

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

Toll Free: (866) 606-3889
TTY/TDD: 711
On Line: https://MolinaHealthcare.AlertLine.com
Email: civil.rights@MolinaHealthcare.com

Facilities, Equipment and Personnel

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

Provider Data Accuracy and Validation

It is important for providers to ensure Molina has accurate practice and business information. Accurate information allows us to better support and serve our provider network and members.

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

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

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

Please visit our POD at https://providersearch.MolinaHealthcare.com to validate and correct most of your information. A convenient provider web form can be found on the POD and additionally on the Provider Portal at https://provider.MolinaHealthcare.com, or 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, prior authorization status inquiries, health plan access to electronic medical records (EMR), electronic claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic claims appeal and registration for and use of Molina's Provider Portal.

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

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

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

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

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

Electronic Solutions/Tools Available to Providers

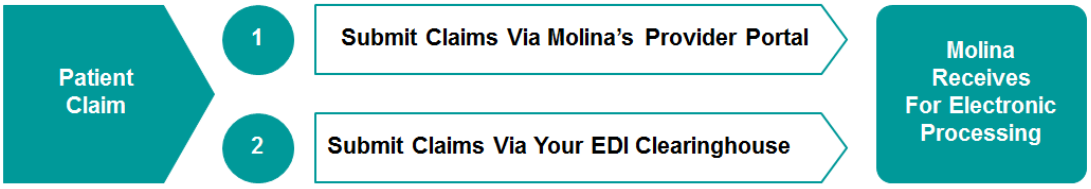
Electronic Tools/Solutions available to Molina Providers include:
- Electronic claims submission options.
- Electronic payment (Electronic Funds Transfer) with Electronic Remittance Advice (ERA)
- Provider Portal.

Electronic Claims Submission Requirement

Molina requires participating providers to submit claims electronically. Electronic claims submission provides significant benefits to the provider including:
- Promotes HIPAA compliance.
- Helps to reduce operational costs associated with paper claims (printing, postage, etc.).
- Increases accuracy of data and efficient information delivery.
- Reduces claim delays since errors can be corrected and resubmitted electronically.

- Eliminates mailing time and claims reach Molina faster.

Molina offers the following electronic claims submission options:
- Submit claims directly to Molina via the Provider Portal. See our Provider Portal Quick Reference Guide at 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/OhioProviders for additional information.



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

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

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

Electronic Payment (EFT/ERA) Requirement

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

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/OhioProviders.

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

Provider Portal

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

- Verify and print member eligibility
- View member benefits, covered services and health record
- Access member roster to view a list of assigned membership for PCP(s)
- Claims functions
  - Professional and Institutional claims (individual or multiple claims)
  - Receive notification of claims status change
  - Correct claims
  - Void claims
  - Add attachments to previously submitted claims
  - Check claims status
  - Export claims reports
  - Create and manage claim templates
  - Open saved claims
- Prior authorizations/service requests
  - Create and submit prior authorization/service requests
  - Check status of prior authorization/service requests
  - Receive notification of change in status of authorization/service requests
  - Create service request/authorization templates
- View HEDIS® scores and compare to national benchmarks
- Appeals
  - Create and submit a claim appeal
  - Add appeal attachments to appeal
  - Receive email confirmation

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

Balance Billing

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

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

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

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

Member Information and Marketing

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

Member Rights and Responsibilities

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

Member Eligibility Verification

Providers should verify eligibility of Molina members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility.

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

Member Cost Share

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

Healthcare Services (Utilization Management and Care 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 this Provider Manual for additional details about these and other Healthcare Services programs.

In Office Laboratory Tests

Molina's policies allow only certain lab tests to be performed in a physician's office regardless of the line of business. All other lab testing must be referred to an In-Network Laboratory Provider 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/OhioProviders.

For more information about In-Network Laboratory Providers, please consult the Molina Provider Online 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 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 Provider 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 made. 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 Marketplace. In the case of emergency services, providers may direct members to an appropriate service including but not limited to primary care, urgent care and emergency services. There may be circumstances in which referrals may require an out of network provider; prior authorization will be required from Molina except in the case of emergency services.

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

Admissions

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

Participation in Utilization Review and Care Management Programs

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

Continuity and Coordination of Provider Communication

Molina stresses the importance of timely communication between providers involved in a member's care. This is especially critical between specialists, including behavioral health providers and the member's PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings. Each year, we review feedback received from PCPs, specialists and facilities to determine if the level of satisfaction with the information provided across settings or between providers is sufficient.

Treatment Alternatives and Communication with Members

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

Pregnancy Notification Process

Molina contracted providers should notify the Molina Utilization Management department when providing care to pregnant members. This notification helps Molina 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 within twenty-four (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 provider website. Providers may access additional Opioid-Safety and Substance Use Disorder resources at www.MolinaHealthcare.com/OhioProviders under the Health Resource tab. Please consult with your Provider Services representative or reference the medication formulary for more information on Molina's Pain Safety Initiatives.

Participation in Quality Programs

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

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

Access to Care Standards

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

Participation in Grievance and Appeals Programs

Providers are required to participate in Molina's Grievance Program and cooperate with Molina in identifying, processing and promptly resolving all member complaints, grievances or inquiries. If a member has a complaint regarding a provider, the provider will participate in the investigation of the grievance. If a member appeals, the provider will participate by providing medical records and/or statement as needed. This includes the maintenance and retention of member records for a period of not less than ten (10) years, and retained further if the records are under review or audit until such time that the review or audit is complete.

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

Participation in Credentialing

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

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

More information about Molina's Credentialing program, including Policies and Procedures is available in the Credentialing and Recredentialing 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.

3. Cultural Competency and Linguistic Services

Background

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

Additional information on cultural competency and linguistic services is available at www.MolinaHealthcare.com/OhioProviders, 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

Cultural Competency

Molina is committed to reducing health care disparities. Training employees, providers and their staffs, and quality monitoring are the cornerstones of successful culturally competent service delivery. Molina integrates Cultural Competency training into the overall provider training and quality monitoring programs. An integrated quality approach intends to enhance the way people think about our members, service delivery and program development so that cultural competency becomes a part of everyday thinking.

Provider and Community Training

Molina offers educational opportunities in cultural competency concepts for providers, their staff, and Community Based Organizations. Molina conducts provider training during provider orientation with annual reinforcement training offered through Provider Services or online/webinar training modules.

Training modules, delivered through a variety of methods, include:
1. Written materials;
2. On-site cultural competency training
3. Online cultural competency provider training; and,
4. Integration of cultural competency concepts and nondiscrimination of service delivery into provider communications

Integrated Quality Improvement – Ensuring Access

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

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

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

24 Hour Access to Interpreter Services

Providers may request interpreters for members whose primary language is other than English by calling Molina's Contact Center toll free at (855) 322-4079. If Contact Center Representatives are unable to interpret in the requested language, the representative will immediately connect you and the member to a qualified language service provider.

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

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

Documentation

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

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

Members who are Deaf or Hard of Hearing

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

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

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

Nurse Advice Line

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

4. Member Rights and Responsibilities

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

EOCs are available on the Provider Portal at https://Provider.MolinaHealthcare.com and Molina's Member Website at www.MolinaHealthcare.com/Marketplace. 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.

5. Eligibility, Enrollment, Disenrollment & Grace Period

Enrollment in Molina Marketplace

The Centers for Medicare and Medicaid Services (CMS) 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 CMS 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 thirty-one (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 sixty (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:

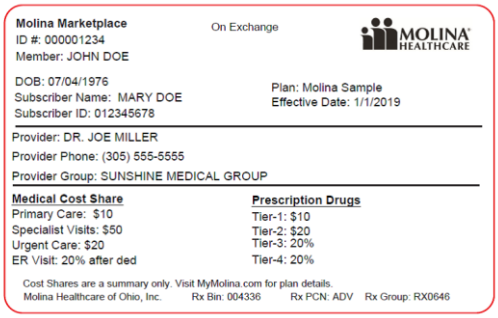
- Molina Provider Portal https://provider.MolinaHealthcare.com.
- Molina Provider Services at (855) 322-4079

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.

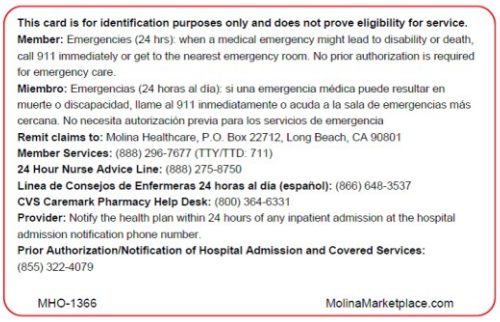
Identification Cards

Molina 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:

- 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 > twenty-six (26))

PCP Assignment

Molina will offer each member a choice of 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, and
- age (adults versus children/adolescents)

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

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

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

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

Summary

The Affordable Care Act mandates that all qualified health plans offering insurance through the Health Insurance Marketplace provide a grace period of three (3) consecutive 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 ten (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.

Eligibility Messages

When a member is in the grace period, Molina will include an eligibility message on the Provider Portal, interactive voice response (IVR) and in the call centers. This message will provide information about the member's grace period status, including which month of the grace period that the member is in (first, second or third), as well as information about how authorizations and claims will be processed during this time. Providers should verify both the eligibility status AND any eligibility messages when checking a member's eligibility. For additional information about how authorizations and claims will be processed during this time, please refer to the Member Evidence of Coverage, or contact 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 and update the member's eligibility status on the provider portal. The notification will inform providers as follows:

- Members who receive APTC and have entered the first month of the grace period will not have any service restrictions. Therefore, the message that providers will see upon checking the provider portal will read as follows: No Enrollment Restrictions
- Providers will be notified and are able to check that the APTC member entered the second or third months of the grace period.
- All providers and specifically, providers who have submitted claims for the APTC member in the two months prior to the start of the grace period will be notified and are able to check that the APTC member entered the second or third months of the grace period.
- Providers will be notified and are able to check if the APTC member is in the second or third months of the grace period before services are rendered and before submitting claims.

The notification and online eligibility message will advise providers that services rendered during the second or third months of the grace period may be denied if the premium is not paid in full prior to the expiration of the third month of the grace period.

Prior Authorizations

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

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

<u>APTC Members:</u>

If the APTC member pays the full premium payment prior to the expiration of the three (3) month grace period, providers may then seek authorization for services. If the APTC member received services during the second or third month of the grace period without

a prior authorization, the provider may request a retro-authorization for those services already rendered. All authorization requests will be reviewed based on medical necessity.

Non-APTC Members:

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

Claims Processing

APTC Members:

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

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

Non-APTC Members:

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

6. Benefits and Covered Services

Molina covers the services described in the Summary of Benefits and Evidence of Coverage (EOC) documentation for each Molina Marketplace plan type. If there are questions as to whether a service is covered or requires prior authorization, please contact Molina at (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 is listed in the Schedule of Benefits located in the EOC. Cost Sharing applies to all covered services except for preventive services included in the Essential Health Benefits (as required by the Affordable Care Act). Cost Sharing towards Essential Health Benefits may be reduced or eliminated for certain eligible members, as determined by Marketplace's rules.

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

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

The following web link provides access to the Summary of Benefits guides and Evidence of Coverage for the 2019 Molina Marketplace products offered in Ohio.

Detailed information about benefits and services can be found in the 2019 Evidence of Coverage (EOC) booklets that made available to Molina Marketplace members.

- https://www.molinahealthcare.com/members/oh/en-US/hp/marketplace/plans/Pages/allplans.aspx

Obtaining Access to Certain Covered Services

Prescription Drugs

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

by contacting Molina at (888) 296-7677, (855) 322-4079 or at www.MolinaHealthcare.com

Non-Formulary Drug Exception Request Process

There are two (2) types of requests for clinically appropriate drugs that are not covered under the member's Marketplace plan type:

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

Mail Order Availability of Drug Formulary Prescription Drugs

Molina offers members a mail order option for prescription drugs on Our Drug Formulary. This option applies only to drugs listed in the formulary with the designation "MAIL." These prescription drugs can be mailed to members within ten (10) days from order request and approval. Cost Sharing for a ninety (90)-day supply by mail order is two (2) times the Cost Sharing listed on the Schedule of Benefits for a standard thirty (30)-day supply.

Members may request mail order service in the following ways:

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

payment.
- Providers can call, fax or electronically prescribe using the toll-free FastStart® physician number (800) 378-5697. To speed up the process, providers will need the Molina Marketplace member number (found on the ID card), member date of birth, and member mailing address.

Injectable and Infusion Services

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

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

Access to Mental Health and Substance Abuse Services

Members in need of mental health or substance abuse services can be referred by their PCP for services or members can self-refer by calling Molina's Behavioral Health department at (888) 296-7677.

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

Emergency Mental Health or Substance Abuse Services

Members are directed to call 911 or go to the nearest emergency room if they need emergency mental health or substance abuse services. Examples of emergency mental health or substance abuse problems are:
- Danger to self or others.
- Things that will likely cause death or serious bodily harm.
- Extreme inability to care for oneself as a result of a mental condition or acute intoxication to the point that one would be in danger or place others in danger.

Out of Area Emergencies

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

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

For out-of-area emergency care, plans will be made to transfer members to an in-network facility when member is stable.

Obtaining Mental Health or Substance Abuse Services

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

Emergency Transportation

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

Non-Emergency Medical Transportation

For Molina Marketplace members, non-emergency medical transportation is a covered service. Molina covers transportation from hospital or Skilled Nursing Facility to another medical facility to obtain medically necessary services. This service must be arranged through a network transportation provider. Members must have prior authorization from Molina for ground and air ambulance services before the services are given. 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, 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 twenty-four (24) hours a day, seven (7) days a week, to assess symptoms and help make good health care decisions.

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

Molina is committed to helping our members:
- Prudently use the services of your office.
- Understand how to handle routine health problems at home.
- Avoid making non-emergent visits to the emergency room (ER).

These registered nurses do not diagnose. They assess symptoms and guide the patient to the most appropriate level of care following specially designed algorithms unique to the Nurse Advice Line. The Nurse Advice Line may refer back to the PCP, a specialist,

911 or the ER. By educating patients, it reduces costs and over utilization on the health care system.

Health Management Programs

Molina's Health Management programs provide patient education information to members and helps facilitate provider access to these chronic disease programs and services. Health management staff; registered nurse, registered dietitian, licensed vocational nurse, social worker, and/or health educator are available telephonically to share information about Molina programs. They will assist members with preventative education and management of their conditions. He/she will collaborate with the member and provider relating to specific needs identified for best practices. Molina requests that you as a provider also help us identify members who may benefit from these programs. Members can request to be enrolled or dis-enrolled in these programs. These include programs, such as:

- Asthma
- Depression
- Weight management
- Smoking cessation

For more info about our programs, please call:

- Provider Services department at (855) 322-4079
- 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 Care 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 care 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 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℠ Program

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

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 (UM)

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 to ensure efficiency of the health care services across the continuum of care;
- Defining the review criteria, information sources and processes that are used to review and approve the provision of items and services, including prescription drugs;
- Coordinating, directing, and monitoring the quality and cost effectiveness of health care resource utilization while monitoring utilization practice patterns of providers, hospitals and ancillary providers to identify over and under service utilization;
- Implementing comprehensive processes to monitor and control the utilization of health care resources;
- Ensuring that services are available in a timely manner, in appropriate settings, and are planned, individualized and measured for effectiveness;
- Reviewing processes to ensure care is safe and accessible;
- Ensuring that qualified health care professionals perform all components of the UM/CM processes while ensuring timely responses to member appeals and grievances;

- Ensuring that UM decision tools are appropriately applied in determining medical necessity decision;
- Identify and assess the need for 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;
- 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; and,
- Process authorization requests timely and with adherence to all regulatory and accreditation timeliness standards.

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

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

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

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

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

Medical Necessity Review

Molina only reimburses for services that are medically necessary. To determine medical necessity, in conjunction with independent professional medical judgment, Molina will use nationally recognized guidelines, which include but are not limited to 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 care 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 Current Procedural Technology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes. Molina prior authorization documents are customarily updated quarterly, but may be updated more frequently as appropriate, and the current documents are posted on the Molina website at www.MolinaHealthcare.com.

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

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

- Member demographic information (name, date of birth, Molina ID number, 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 forty-eight (48) 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 ten (10) 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.

Requesting Prior Authorization

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

The benefits of submitting your prior authorization request through the Provider Portal are:

- Create and submit prior authorization requests.
- Check status of prior authorization requests.
- Receive notification of change in status of prior authorization requests.
- Attach medical documentation required for timely medical review and decision making.

Fax: The prior authorization 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 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, Inc.
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.

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.

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

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

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

Levels of Administrative and Clinical Review

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

- Administrative (e.g., eligibility, appropriate vendor or participating provider, covered services); and,
- Clinical (e.g., medically necessary)

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

All staff involved in the review process have an updated list of services and procedures that require pre-service authorization.

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

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

Hospitals

Emergency Services

Emergency Services means: 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 Care Managers whenever possible to determine the reason for using emergency services.

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

Admissions

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

Inpatient Management

Elective Inpatient Admissions

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

Emergent Inpatient Admissions

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

Inpatient at time of Termination of Coverage

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

Prospective/Pre-Service Review

Pre-service review defines the process, qualified personnel and timeframes for accepting, evaluating and replying to prior authorization requests. Pre-service review is required for all non-emergent inpatient admissions, outpatient surgery and identified procedures, home health, some durable medical equipment (DME) and out-of-area/out-of-network professional services. The pre-service review process assures the following:

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

- The PCP is kept apprised of service requests and of the service provided to the member by other providers.

Inpatient Review

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

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

Inpatient Status Determinations

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

Discharge Planning

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

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

Pre-Service and Post-Service Authorization Reconsiderations

Molina provides pre-service and post-service authorization reconsiderations to providers through the peer-to-peer review and authorization reconsideration processes described below.

Peer-to-Peer Review Process

Network providers may request a Peer-to-Peer review ("P2P") within five (5) calendar days of the date on the authorization denial notification.
To make the Peer-to-Peer request:

- Call Molina Healthcare Utilization Management at (855) 322-4079 or Advance Imaging at (877) 731-7218 from 8:30 a.m. to 5:00 p.m., Monday to Friday.
- Include two (2) possible dates and times a **licensed professional** is available to conduct the review with a Molina Medical Director.

If the Peer-to-Peer does not change the outcome of a determination, or is not requested within five (5) days, providers may request an authorization reconsideration within thirty (30) days of the date on the authorization denial notification. The authorization reconsideration must include new/additional clinical information to be considered. Once a determination has been rendered for the authorization reconsideration, no further authorization reconsiderations are available.

Authorization Reconsideration Process

Submit an authorization reconsideration only when disputing a level of care determination, a medical necessity denial with new/additional clinical information, or a retro authorization for Extenuating Circumstances only. Below is the list of Extenuating Circumstances that apply to both inpatient and outpatient authorization requirements. Within one hundred twenty (120) days of the claim denial, the provider may file for an authorization reconsideration even if the authorization was not requested in advance of the service(s) being provided. The specific circumstance the provider feels was applicable to the request should be noted on the reconsideration form, documentation to support the extenuating circumstance, as well as the applicable clinical information should be included with the request. In accordance with Molina policy, please remember to always verify eligibility with Molina.

Extenuating Circumstances—below is the list of Extenuating Circumstances that apply to both inpatient and outpatient authorization requirements. Within one-hundred-twenty (120) days of the claim denial, the provider may file for an authorization reconsideration for the extenuating circumstances listed below; even if the authorization was not requested in advance of the service(s) being provided. The specific circumstance the provider feels was applicable to the request should be noted on the reconsideration form, documentation to support the extenuating circumstance, as well

as the applicable clinical information should be included with the request. In accordance with Molina policy, please remember to always verify eligibility with Molina.

- A newborn remains an inpatient longer than the mother and needs a separate authorization
- Member was brought into facility unconscious and/or unable to provide insurance carrier information (Requires provider to submit copy of registration face sheet and full description of why the documentation could not be obtained from the member. In addition, Molina will review claims/authorizations history for the past 6 months for validation purposes.)
- Retro-enrollment/retro coordination of benefits (COB) change makes Molina Healthcare the primary carrier
- Transition of Care/Continuity of Care
- Abortion/Sterilization/Hysterectomy (operative reports are required)
- The service is not an included benefit in the primary insurance coverage (example: no maternity care benefits)
- A baby is born to a member with other third party primary coverage and the baby is not covered under such coverage
- Add-on codes, or changes in coding during the procedure (operative reports are required as applicable)
- Other circumstances as determined by Molina

Also refer to the Provider Reference Guide detailing Molina's authorization and claims reconsideration processes.

An Authorization Reconsideration can be submitted via Molina's Provider Portal (only if a claim has been filed) or fax within thirty (30) calendar days of the date on the authorization denial notification.

Instructions for Provider Portal submissions (if a claim has been filed):

- You can access the Provider Portal at www.molinahealthcare.com/provider
- You will need to log in with your User ID and Password
- Open the claims drop down menu from the home page
- Search for the claim associated with the authorization you would like to have reconsidered by the claim ID or patient information
- Once the search function has identified the claim, select the claim ID number to populate the claim details
- At the bottom of the claim details will be the "Appeal Claim" button
  Once selected, the appeal form to be completed will appear with some information pre-populated, please add a brief explanation of what is being requested noting the submission is an "authorization reconsideration", and you will have the option of adding supporting documents as an attachment

For more details please find our Claim Features training on our website under the Manual Tab

Instructions for Fax Submissions

Requests must include:

- The Authorization Reconsideration Form must be filled out entirely and include the following details, or it will not be processed and the provider will be notified:
  - Molina-assigned Claim number (if applicable)
  - Molina-assigned Authorization number
  - Line of Business
  - Member Name
  - Member ID Number
  - Date(s) of Service
  - Justification for the reconsideration
  - If sending an encrypted disc, provide your password on the Authorization Reconsideration Form
- Appropriate medical documentation supporting an overturn of the decision. This must be new or additional information to the original request. If this detail is not included, the request will be denied and no further review will be completed. Only one (1) submission will be accepted. Any additional submissions for the same service will be denied even if it includes new/additional information.
- Disc Submission: Larger files may not be able to process through our Provider Portal or fax. These large files can be submitted by disc to ensure they are received and processed timely. Follow the policy below when submitting as a disc:
  - Submit one (1) medical record per disc. Those received with more than one (1) medical record will not be processed and the provider will be notified.
  - Complete an authorization reconsideration form (if submitting via fax).
  - If you will be submitting an encrypted disc, please write the password on the completed authorization reconsideration form and indicate that the disc is to follow.
  - If the authorization reconsideration form submission is received with incomplete or missing information it will not be processed and the provider will be notified.
  - Place the Molina-assigned claim ID number on the disc.
  - Discs will be not be processed and the provider will be notified if we cannot access the data.

    Mail discs to: Molina Healthcare of Ohio
    Attn: Provider Inquiry Research and Resolution
    P.O. Box 349020
    Columbus, OH 43234-9020

The Authorization Reconsideration Form can be found at www.MolinaHealthcare.com/OhioProviders.

Readmissions

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

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

Exceptions

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

Non-Network Providers and Services

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

Except for emergency services and out-of-area urgent care services, Marketplace members must receive covered services from participating providers; otherwise, the services are not covered. Marketplace members will be one-hundred percent (100%) responsible for payment and the payments will not apply to towards deductibles or annual out-of-pocket maximums.

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

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

There are two (2) main coordination of care processes for Molina members. The first occurs when a new member enrolls in Molina and needs to transition medical care to Molina contracted providers. There are mechanisms within the enrollment process to identify those members and reach out to them from the Member & Provider Contact Center (M&PCC) to assist in obtaining authorizations, transferring to contracted Durable Medical Equipment (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.

UM Decisions

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

- Determination to authorize, provide or pay for services (favorable determination);
- Determination to deny requests (adverse determination);
- Discontinuation of a service;
- Payment for temporarily out-of-the-area renal dialysis services; and,
- 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 the 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 and/or Neglect

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

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

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

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

Child Abuse:

The Ohio Department of Job and Family Services has launched 855-O-H-Child (855-642-4453), an automated telephone directory that will link callers directly to a child welfare or law enforcement office in their county.

Adult Abuse:

Adult protective services for adults age 60 and older can be reached at the Ohio Department of Job and Family Services at 855-OHIO-APS (855-644-6277).

Molina's HCS teams will work with PCPs and medical groups/IPA and other delegated entities who are obligated to communicate with each other when there is a concern that a member is being abused. Final actions are taken by the PCP/medical group/IPA,

other delegated entities or other clinical personnel. Under state and federal law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation or self-neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

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

Emergency Services and Post-Stabilization Services

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

Emergency services are covered on a twenty-four (24) hour basis without the need for prior authorization for all members experiencing an emergency medical condition.

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

For members within our service area: Molina contracts with vendors that provide twenty-four (24) hour emergency services for ambulance and hospitals. An out-of-network emergency hospital stay will be covered until the member has stabilized sufficiently to transfer to a participating provider facility. Services provided after stabilization in a non-participating provider facility are not covered, and member will be responsible for payment. Member payments to the non-participating provider facility will not apply to the member's deductible or annual out-of-pocket maximum.

Continuity and Coordination of Provider Communication

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

Care Management

Molina Care Management includes Health Management (HM) and Care 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 care 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 care 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 care manager, providers and the member are responsible for implementing the plan of care. Additionally the care 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, healthy 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.

Care Management (CM)

Molina provides a comprehensive Care 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 care 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 care manager will arrange individual services for members whose needs include ongoing medical care, home health care, rehabilitation services and preventive services. The Molina care 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 care 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 care manager with demographic, health care and social data about the member being referred.

Members with the following conditions may qualify for Care Management and should be referred to the Molina 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 (2) weeks of treatment
- Member accessing ER services inappropriately

Referrals to the CM program may be made by contacting Molina at:
Phone: (855) 322-4079.

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.

New Food and Drug Administration (FDA) approved drugs are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the Molina Pharmacy and Therapeutics Committee.

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 Molina. In determining whether a service is experimental/investigational, Molina 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 Institutional Review Board (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 Molina member’s Evidence of Coverage document.

Please refer to the Claims Decisions, Internal Appeals, and External Review section of the Molina member’s Evidence of Coverage document for information about Independent Medical Review related to denied requests for experimental or investigational services.

8. Quality

Maintaining Quality Improvement Processes and Programs

Molina maintains a Quality department to work with members and providers in administering the Molina Quality Improvement Program. You can contact the Molina Quality department **toll free at (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 Quality Improvement Program (QIP). For a complete copy of Molina's QIP you can contact your Provider Services Representative or call the telephone number above to receive a written copy.

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

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

- Have a Quality Improvement Program in place;
- Comply with and participate in Molina's Quality Improvement Program including reporting of Access and Availability survey and activity results and provision of medical records as part of the HEDIS® review process and during Potential Quality of Care and/or Critical Incident investigations; and,
- Allow access to Molina Quality personnel for site and medical record review processes.

Patient Safety Program

Molina's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina members in collaboration with their PCPs. Molina continues to support safe personal health practices for our members through our safety program, pharmaceutical management and care 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, Critical Incident (as applicable) and/or service issues affecting member care. Molina will research, resolve, track and trend issues. Confirmed Adverse Events/Never Events are reportable when related to an error in medical care that is clearly identifiable, preventable and/or found to have caused serious injury or death to a patient. Some examples of never events include:

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

Medical Records

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

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

Medical Record Keeping Practices

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

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

Content

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

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

- A signed document stating with whom protected health information may be shared.

Organization

- The medical record is legible to someone other than the writer;
- Each patient has an individual record;
- Chart pages are bound, clipped or attached to the file;
- Chart sections are easily recognized for retrieval of information; and,
- A release document for each member authorizing Molina to release 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;
- A storage system for inactive patient medical records which allows retrieval within twenty-four (24) hours, is consistent with state and federal requirements, and the record is maintained for not less than ten (10) years from the last date of treatment or for a minor, one (1) year past their 20th birthday but, never less than ten (10) years; 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;
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information; and,
- Education and training for all staff on handling and maintaining protected healthcare information.

Additional information on medical records is available from your local Molina Quality 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 PCPs (adult and pediatric) and participating specialist (to include OB/GYN, behavioral health providers, high volume and high impact specialists). Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on ninety-five percent (95%) availability for emergency services and eighty percent (80%) or greater for all other services. The PCP or his/her designee must be available twenty-four (24) hours a day, seven (7) days a week to members.

Appointment Access

All providers who oversee the member's health care are responsible for providing the following appointments to Molina members in the timeframes noted:

Category	Type of Care	Access Standard
Primary Care Physicians (PCPs):	Emergency needs	Immediately upon presentation
	Urgent care	No later than the end of the following business day after the patent's initial contact with the PCP site
	Regular and routine care	Not to exceed six (6) weeks
OB/GYN	Pregnancy (initial visit)	Within two (2) weeks
	Routine visit	Within six (6) weeks
Non-PCP Specialist	Emergency needs	Immediately upon presentation
	Urgent care	Not to exceed twenty-four (24) hours
	Regular and routine care	Within eight (8) weeks
Behavioral Health Specialists	Emergency needs	Immediately upon presentation
	Non-life threatening emergency	Not to exceed six (6) hours
	Urgent care	Not to exceed forty-eight (48) hours
	Initial visit for routine care	Not to exceed ten (10) business days
	Follow-up routine care	Not to exceed ten (10) calendar days based off the condition
All	After-hours care	Must be available by phone twenty-four (24) hours a day, seven (7) days a week
	Office wait time	Maximum of thirty (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 obstetric and gynecological care from an in-network obstetrician or gynecologist or directly from a participating PCP designated by Molina as providing obstetrical and gynecological services. Member access to obstetrical and gynecological services is monitored to ensure members have direct access to participating providers for obstetrical and gynecological services. Gynecological services must be provided when requested regardless of the gender status of the member.

Additional information on access to care is available under the Resources tab on the www.MolinaHealthcare.com/OhioProviders website or from your local Molina Quality department **toll free at (855) 322-4079**.

Monitoring Access for Compliance with Standards

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

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

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

Analysis of access data includes assessment of performance against established standards, review of trends over time, and identification of barriers. Results of analysis are reported to the Quality Improvement Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified provider-specific or organizational

trends. Performance goals are reviewed and approved annually by the Quality Improvement Committee.

Additional information on access to care is available under the Resources tab at www.MolinaHealthcare.com/OhioProviders 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 offices of all providers meet its office-site and medical record keeping practices standards. Molina continually monitors member complaints/grievances for all office sites to determine the need of an office site visit and will conduct office site visits within sixty (60) calendar days. Molina assesses the quality, safety and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This form includes the Office Site Review Guidelines and the Medical Record Keeping Practice Guidelines (as outlined above under "Medical Record Keeping Practices") and the thresholds for acceptable performance against the criteria. This includes an assessment of:

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

Physical Accessibility

Molina evaluates office sites 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 Record Keeping Practices" section above. To ensure member confidentiality, Molina reviews a "blinded" medical/treatment record or a "model" record instead of an actual record.

Monitoring Office Site Review Guidelines and Compliance Standards

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

Administration & Confidentiality of Facilities

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

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted, and parking area and walkways demonstrate appropriate maintenance.
- Handicapped parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is handicapped accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two (2) office exam rooms per physician.
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one CPR certified employee is available
- Yearly OSHA training (Fire, Safety, Blood borne Pathogens, etc.) is documented for offices with ten (10) or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, and contracts (evidence of a hazardous waste management system in place).
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.

- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A CLIA waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double locked. Medication and sample access 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 (CAP) to Molina within thirty (30) calendar days.
- Send notification that another review will be conducted of the office in six (6) months.

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

Additional reviews are conducted at the office at six (6)-month intervals 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 (3) types of Advance Directives:

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

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

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

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

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

PCPs must discuss Advance Directives with a member and provide appropriate medical advice if the member desires guidance or assistance.

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

In no event may any provider refuse to treat a member or otherwise discriminate against a member because the member has completed an Advance Directive. CMS law gives members the right to file a complaint with Molina or the state survey and certification agency if the member is dissatisfied with Molina's handling of Advance Directives and/or if a provider fails to comply with Advance Directives instructions.

Molina will notify the provider via fax of an individual member's Advance Directives identified through care management or care coordination. 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 preventative services necessary for enrollees under twenty-one (21) years are timely according to required preventive health guidelines. All enrollees under twenty-one (21) years of age should receive screening examinations including appropriate childhood immunizations at intervals as specified by the by the preventive health guidelines located on the Molina website (www.MolinaHealthcare.com) and referenced in the Benefits and Covered Services section of this Provider Manual.

Well Child/Adolescent Visits

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

- Comprehensive health and developmental history.
- Nutritional assessment.
- Height and weight and growth charting.
- Comprehensive unclothed physical examination.
- Appropriate immunizations;
- Laboratory procedures, including lead blood level assessment appropriate for age and risk factors.
- Periodic developmental and behavioral screening.
- Vision and hearing tests.
- Dental assessment and services.
- Health education (anticipatory guidance including child development, healthy lifestyles and accident and disease prevention).

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

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

Monitoring for Compliance with Standards

Molina monitors compliance with the established performance standards as outlined above at least annually. Within thirty (30) calendar days of the review, a copy of the review report and a letter will be sent to the medical group notifying them of their results. Performance below Molina's standards may result in a CAP with a request to the provider to 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 Care Management (CM) programs. Members may qualify for HM or CM based on confirmed diagnosis or specified criteria for the programs. These comprehensive programs are available for all members that meet the criteria for services. For additional information please see the Care Management heading in the Healthcare Services section of this Provider Manual.

Clinical Practice Guidelines

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

Molina Clinical Practice Guidelines include the following:

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

The adopted CPGs are distributed to the appropriate providers, provider groups, staff model facilities, delegates and members by the Quality, Provider Services, Health Education and Member Services departments. The guidelines are disseminated through Provider Newsletters, Provider Bulletins and other media and are available on the Molina website. Individual providers or members may request copies from the local Molina Quality department **toll free at (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 twenty-four (24) months old.
- Care for children two to nineteen (2-19) years old.
- Care for adults twenty to sixty-four (20-64) years old.
- Care for adults sixty-five (65) years and older.
- Immunization schedules for children and adolescents.
- Immunization schedules for adults.

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

Cultural and Linguistic Services

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

Measurement of Clinical and Service Quality

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

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

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

Contracted providers and facilities must allow Molina to use its performance data collected in accordance with the provider's or facility's contract. The use of performance data may include, but is not limited to, the following:

1) development of Quality Improvement activities;
2) public reporting to consumers;
3) preferred status designation in the network; and/or,
4) reduced member cost sharing.

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

Healthcare Effectiveness Data and Information Set® (HEDIS)

Molina utilizes the NCQA© HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the Spring. The data comes from on-site

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

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

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

Experience of Care and Health Outcomes® (ECHO) Survey

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

Qualified Health Plan (QHP) Enrollee Experience Survey

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

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

QHP Enrollee Survey topics include:

- Access to care
- Access to information
- Care coordination
- Cost
- Cultural competence
- Customer service
- Doctor communication

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

Provider Satisfaction Survey

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

Effectiveness of Quality Improvement Initiatives

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

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

Quality Rating System

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

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

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

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

- Clinical effectiveness
- Patient safety
- Prevention
- Access
- Doctor and care
- Efficiency and affordability
- Plan service

What Can Providers Do?

- Ensure patients are up-to-date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology;
- Review the HEDIS® preventive care listing of measures for each patient to determine if anything applicable to your patients' age and/or condition has been missed;
- Check that staff is properly coding all services provided; and,
- Be sure patients understand what *they* need to do.

Molina has additional resources to assist providers and their patients. For access to tools that can assist, please visit Molina's website and click on Health Care Professionals. There is a variety of resources, including:

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

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 the education of appropriate employees, vendors, providers and associates doing business with Molina.

Molina's Special Investigation Unit (SIU) supports Compliance in its efforts to deter and prevent fraud, waste and abuse by conducting investigations aimed at identifying suspect activity and reporting these findings to the appropriate regulatory and/or law enforcement agency.

Mission Statement

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

Regulatory Requirements

Federal False Claims Act

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

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

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

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

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

Anti-Kickback Statute

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

Sarbanes-Oxley Act of 2002

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

Definitions

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

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

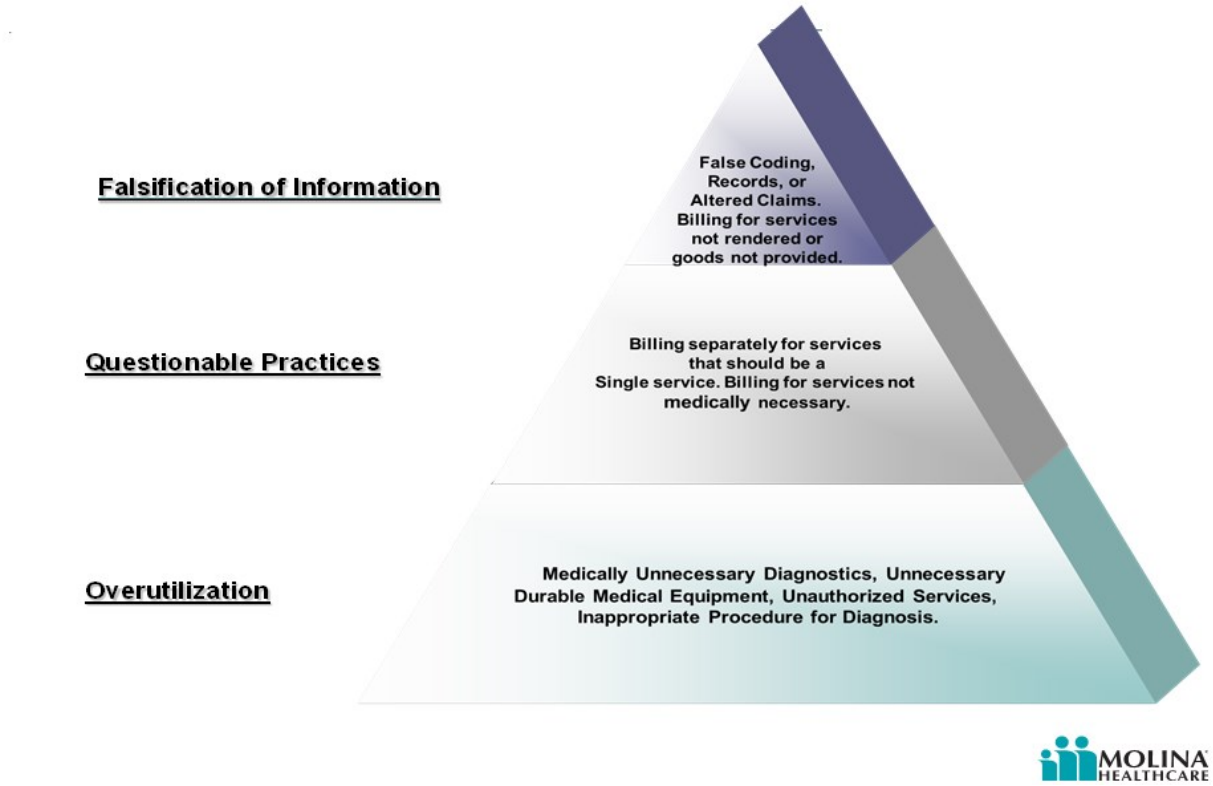
Abuse: means provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary costs to the Marketplace program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.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

Examples of Fraud, Waste and Abuse by a Provider

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

- Altering claims and/or medical record documentation in order to get a higher level of reimbursement.

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



Examples of Fraud, Waste and Abuse by a Member

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

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

Review of Provider Claims and Claims System

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

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

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

Prepayment Fraud, Waste and Abuse Detection Activities

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

Post-payment Recovery Activities

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

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

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

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

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

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

Provider Education

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

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

Reporting Fraud, Waste and Abuse

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

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

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

Molina Healthcare of Ohio, Inc.
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 Office at: (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)
   - 42 C.F.R. Part 2
   - Medicare and Medicaid Laws
   - The Affordable Care Act

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

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a provider may use and disclose PHI for their own treatment, payment and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the provider's own TPO activities, but also for the TPO of another covered 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

[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

- Care management and care coordination
- Training programs
- Accreditation, licensing, and credentialing

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

Confidentiality of Substance Use Disorder Patient Records

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

Inadvertent Disclosures of PHI

Molina may, on occasion, inadvertently misdirect or disclose PHI pertaining to Molina member(s) who are not the patients of the provider. In such cases, the provider shall return or securely destroy the PHI of the affected Molina members in order to protect their privacy. The provider agrees to not further use or disclose such PHI and further agrees to provide an attestation of return, destruction and non-disclosure of any such misdirected PHI upon the reasonable request of Molina.

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable state law. A sample Authorization for the Use and Disclosure of Protected Health Information is included at the end of this section.

Patient Rights

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

1. Notice of Privacy Practices

Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient

should follow to exercise those rights. The provider should obtain a written acknowledgment that the patient received the notice of privacy practices.

2. **Requests for Restrictions on Uses and Disclosures of PHI**
   Patients may request that a health care provider restrict its uses and disclosures of PHI. The provider is not required to agree to any such request for restrictions.

3. **Requests for Confidential Communications**
   Patients may request that a health care provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.

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

5. **Request to Amend PHI**
   Patients have a right to request that the provider amend information in their designated record set.

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

HIPAA Security

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

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

HIPAA Transactions and Code Sets

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

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

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

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

Code Sets

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

National Provider Identifier

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

Additional Requirements for Delegated Providers

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

Reimbursement for Copies of PHI

Molina does not reimburse providers for copies of PHI related to our 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 and Grievance
- Anti-Fraud Program Review
- Quality of Care Issues
- Regulatory Audits
- Risk Adjustment
- Treatment, Payment and/or Operation Purposes
- Collection of HEDIS® Medical Records.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member Name:_____ Member 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:

_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____

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

6. 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.

7. 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.

8. 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.

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

10. 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.

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

12. This authorization expires on the following date or event*: _____

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

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

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

10. Claims and Compensation

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

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

Hospital-Acquired Conditions and Present on Admission Program

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

The following is a list of CMS HACs. Effective Oct. 1, 2008, CMS reduces payment for hospitalizations complicated by these categories of conditions that were not 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 Inpatient Prospective Payment System (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 20149.

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

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

Required Elements

The following information must be included on every claim:

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

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

National Provider Identifier (NPI)

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

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 at https://provider.MolinaHealthcare.com
- 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 (Provider 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 iInstitutional. 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

Participating providers should submit claims electronically. If electronic submission is not possible, please submit paper claims to the following address:
Molina Healthcare of Ohio, Inc.
P.O. Box 22712
Long Beach, CA 90801

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

For members enrolled in a Molina Marketplace plan, Molina is 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 be bundled or billed together and to promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by the same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes Medically Unlikely Edits (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.

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.

Effective Jan. 1, 2018 all professional and outpatient claims with dates of service on or after Jan. 1, 2018, with CPT/HCPC/Rev drug code details must have the corresponding valid NDC code submitted with the CPT/HCPCS drug code.

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:

<u>837P</u>

- 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) of the claim being corrected, which can be found on the remittance advice.

837I

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

Corrected claims must be received by Molina no later than the filing limitation stated in the provider contract or within 365 days of the original remittance advice.

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 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 Remittance Advice (RA) processes. There is no cost to the provider for EFT enrollment, and providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery. 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 claim payment, Molina determines that it has made an overpayment to a provider for services rendered to a member, a claim for such overpayment will be made.

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.

Pre-Service and Post-Service Authorization Reconsiderations

Authorization Reconsiderations for Medical Necessity

For Medicaid and Marketplace services, and also MyCare Ohio inpatient, the provider can request a reconsideration of a prior authorization denial.

An Authorization Reconsideration can be submitted via Molina's Provider Portal (only if a claim has been filed) or fax within thirty (30) calendar days of the date on the authorization denial/ non-approval notification, or until the claim is processed.

Instructions for Provider Portal submissions (if a claim has been filed):

- You can access the Provider Portal at www.MolinaHealthcare.com/provider
- You will need to log in with your User ID and Password
- Open the claims drop down menu from the home page
- Search for the claim associated with the authorization you would like to have reconsidered by the claim ID or patient information
- Once the search function has identified the claim, select the claim ID number to populate the claim details
- At the bottom of the claim details will be the "Appeal Claim" button
- Once selected, the appeal form to be completed will appear with some information prepopulated, please add a brief explanation of what is being requested noting the submission is an "authorization reconsideration", and you will have the option of adding supporting documents as an attachment

For more details please find our Claim Features training on our website under the Manual Tab

Instructions for Fax Submissions

Requests must include:

- The Authorization Reconsideration Form must be filled out entirely and include the following details, or it will not be processed, and the provider will be notified:
  - Molina-assigned Claim number (if applicable)
  - Molina-assigned Authorization number
  - Line of Business
  - Member Name
  - Member ID Number
  - Date(s) of Service
  - Justification for the reconsideration
  - If sending an encrypted disc, provide your password on the Authorization Reconsideration Form
- Appropriate medical documentation supporting an overturn of the decision. This must be new/additional information to the original request. If this detail is not included, the request will be denied, and no further review will be completed.
- Disc Submission: Larger files may not be able to process through our Provider Portal or fax. These large files can be submitted by disc to ensure they are received and processed timely. Follow the policy below when submitting as a disc:
  - Submit one medical record per disc. Those received with more than one medical record will not be processed and the provider will be notified.
  - Complete an authorization reconsideration form (if submitting via fax).
  - If you will be submitting an encrypted disc, please write the password on the completed authorization reconsideration form and indicate that the disc is to follow.
  - If the authorization reconsideration form submission is received with incomplete or missing information, it will not be processed, and the provider will be notified.
  - Place the Molina-assigned claim ID number on the disc.
  - Discs will not be processed, and the provider will be notified, if we cannot access the data.

Mail discs to: Molina Healthcare of Ohio
Attn: Provider Inquiry Research and Resolution
P.O. Box 349020
Columbus, OH 43234-9020

The Authorization Reconsideration Form can be found at www.MolinaHealthcare.com/OhioProviders.

Claim Disputes/Reconsiderations (not related to an Authorization/Medical Necessity Review)

Submit claim reconsiderations only when disputing a payment denial, payment amount or a code edit. **As a reminder:** Primary insurance Explanation of Benefits (EOB), corrected claims, and itemized statements are **not** accepted via claim reconsideration. Please refer to the Corrected Claims submission guidelines.

A Claim reconsideration must be submitted within one-hundred-twenty (120) calendar days from the disputed claim remit date.

- Use the Provider Portal to submit the reconsideration online.
  - You can access the Provider Portal at www.MolinaHealthcare.com/provider
  - You will need to log in with your User ID and Password
  - Open the claims drop down menu from the home page
  - Search for the claim associated with the authorization you would like to have reconsidered by the claim ID or patient information
  - Once the search function has identified the claim, select the claim ID number to populate the claim details
  - At the bottom of the claim details will be the "Appeal Claim" button
  - Once selected, the appeal form to be completed will appear with some information pre-populated and you will have the option of adding supporting documents as an attachment. Please include your fax number in order to receive a timely response
  - Attachments totaling up to 125 MB can be included with the reconsideration request

For more details please find our Claim Features training on our website under the Manual Tab.

- Alternatively, providers may fax the form and supporting documents to the Provider Resolution Team at (800) 499-3406.
  - The Claim Reconsideration Request Form (CRRF) must be filled out entirely and include the following details, or it will not be processed, and the provider will be notified:
    - Molina-assigned Claim Number
    - Line of Business
    - Member Name
    - Member ID Number
    - Date of Service
    - Provider ID/NPI
    - Provider Phone and Fax
    - Detailed Explanation of the Appeal
    - Pricing sheet, if disputing payment amount
    - Supporting documents

Find the form at: www.MolinaHealthcare.com/OhioProviders under "Forms." (Paper submissions received by mail will not be processed and the provider will be notified.)

Only one (1) submission will be accepted. Any additional submissions for the same dispute reason will be denied even if it includes new/additional information.

Billing the Member

- Providers contracted with Molina cannot balance 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:
    - Molina indicates the member is responsible to pay cost-share associated with covered services as indicated on the remittance advice (which includes deductible, coinsurance and copayment amounts).
    - 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 provides Companion Guides with the specific submission requirements available to providers. Please refer to the EDI/ERA/EFT tab on Molina's website: www.MolinaHealthcare.com/OhioProviders.

When your encounters are filed electronically you should receive:

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

11. Complaints, Grievance and Appeals Process

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 wants to know about member concerns and any complaints members may have. Members may file a complaint in writing or by calling us. Molina will respond to member complaints no later than sixty (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

Ohio Department of Insurance Consumer Affairs	
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 care or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations is either of the following:
- Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state;
- In the opinion of the practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

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 one-hundred-eighty (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, 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.*, seventy-two (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 SEVENTY-TWO (72) HOURS
PRE-SERVICE DECISIONS	WITHIN THIRTY (30) CALENDAR DAYS
POST-SERVICES DECISIONS	WITHIN SIXTY (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 under the member's agreement with Molina. Molina will not choose or influence the IRO's reviewers.

There are three (3) 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 thirty (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 seventy-two (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 one-hundred-eighty (180) days of the date of the notice of Final Adverse Benefit Determination issued by Molina.
- 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 ten (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 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 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 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 and require that the request be referred for external review. The Ohio Department of Insurance's decision will be made in accordance with the terms of Molina and all applicable provisions of the law. Molina 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 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. At any time Molina 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 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, the IRO will terminate the review.

In addition to all documents and information considered by Molina 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 the member's agreement with Molina; and,
- The most appropriate practice guidelines.

The IRO will provide a written notice of its decision within thirty (30) days of receipt by Molina of a request for a standard review or within seventy-two (72) hours of receipt by Molina of a request for an expedited review. This notice will be sent to the member, Molina 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 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 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. Members 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.

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 the member's agreement with Molina 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

Requests to dispute the processing, payment or nonpayment of a claim by Molina 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 Portal.
- Fax a completed Claims Reconsideration Request Form with any supporting documentation to (800) 449-3406.

For additional details, please refer to the Claims Disputes/Reconsiderations section of this manual.

Reporting

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

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

Record Retention

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

Provider shall maintain records for a period not less than ten (10) years from the termination of the provider 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 provider contract is continuous.)

12. Credentialing and Recredentialing

The purpose of the Credentialing Program is to assure the Molina 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

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 specialty.

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

Primary Source verification – the process by which Molina verifies credentialing information directly from the entity that originally conferred or issued the credentials to the provider.

Locum Tenens – a substitute physician used to fill in for a regular physician for reasons such as illness, pregnancy, vacation or continuing medical education. The regular

physician bills and receives payment for the substitute physician as though he/she performed them. The substitute physician generally has no practice of his/her own and moves from area to area as needed. The regular physician generally pays the substitute physician a fixed amount per diem, with the substitute physician having the status of an independent contractor rather than of an employee.

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

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

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

Type of Practitioners Credentialed & Recredentialed

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

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

Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction Medicine Specialists
- Audiologists
- Behavioral Healthcare Practitioners (who are licensed, certified or registered by the state to practice independently)
- Chiropractors
- Clinical Social Workers
- Dentists
- Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists
- Medical Doctors (MD)
- Naturopathic Physicians

- Nurse Midwives
- Nurse Practitioners
- Occupational Therapists
- Optometrists
- Oral Surgeons.
- Osteopathic Physicians (DO)
- Pharmacists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Psychiatrists and other physicians
- Psychologist
- Speech and Language Pathologists
- Telemedicine Practitioners

Criteria for Participation in the Molina Network

Molina has established criteria and the sources used to verify these criteria for the evaluation and selection of providers for participation in the Molina network. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Molina network. To remain eligible for participation, providers must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina.

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

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

- **Application** – Provider must submit to Molina a complete credentialing application and signed attestation within 180 days. Application must include all required attachments.
- **License, Certification or Registration** – Provider must hold an active, valid and unrestricted license, certification or registration to practice in their specialty in every state in which they will provide care and/or render services for Molina members.

- **DEA or CDS Certificate** – Provider must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Provider must have a DEA or CDS in every state where the provider provides care to Molina members.
- **Education and Training** – Providers will only be credentialed in an area of practice in which they have adequate education. Provider must have graduated from an accredited school with a degree in their designated specialty.
    - **Residency Training** – Provider must have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing.
    - **Fellowship Training** – If the provider is not board certified in the specialty in which they practice and has not completed a residency program they must have completed a fellowship program from an accredited training program in the specialty in which they are practicing.
- **Board Certification** – Board certification in the specialty in which the provider is practicing is preferred but not required. Verification of board certification is primary source verified directly with the American Board of Medical Specialties.
- **Work History** – Provider must supply most recent five (5)-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional.
- **Malpractice History** – Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application.
- **Professional Liability Insurance** – Provider must supply current professional malpractice liability insurance coverage on application or current copy of certificate. Provider must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina members and the provider's activities on Molina's behalf.
- **Hospital Privileges** – Practitioners must list all current hospital privileges on their credentialing application. If the practitioner has current privileges, they must be in good standing.
- **NPI** – Practitioner must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS).
- **SSA Death Master File** – Practitioners must provide their social security number. That social security number should not be listed on the Social Security Administration Death Master File.

Burden of Proof

The provider shall have the burden of producing adequate information to prove he/she meets all criteria for initial participation and continued participation in the Molina network. This includes but is not limited to proper evaluation of their experience, background, training, demonstrated ability and ability to perform as a provider without limitation, including physical and mental health status as allowed by law, and the burden of resolving any doubts about these or any other qualifications to participate in the

Molina network. If the provider fails to provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina network. Providers who fail to provide this burden of proof do not have the right to submit an appeal.

Provider Termination and Reinstatement

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

If Molina is unable to recredential a provider within thirty-six (36) months because the provider is on active military assignment, maternity leave or sabbatical, but the contract between Molina and the provider remains in place, Molina will recredential the provider upon his or her return. Molina will document the reason for the delay in the provider's file. At a minimum, Molina will verify that a provider who returns has a valid license to practice before he or she can resume seeing patients. Within sixty (60) calendar days of notice, when the provider resumes practice, Molina will complete the recredentialing cycle. If either party terminates their contract and there was a break in service for more than thirty (30) calendar days, Molina will initially credential the provider before the provider rejoins the network.

Credentialing Application

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

- Reason for any inability to perform the essential functions of the position, with or without accommodation;
- Lack of present illegal drug use;
- History of loss of license and felony convictions;

- History of loss or limitation of privileges or disciplinary action;
- Current malpractice insurance coverage; and,
- The correctness and completeness of the application.

Non-Discriminatory Credentialing and Recredentialing

Molina does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation or the types of procedures (e.g. abortions) or patients (e.g. Medicaid or Medicare) in which the provider specializes. This does not preclude Molina from including in its network providers who meet certain demographic or specialty needs; for example, to meet cultural needs of members.

Notification of Discrepancies in Credentialing Information

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

Notification of Credentialing Decisions

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

Providers Rights during the Credentialing Process

Providers have the right to review their credentials file at any time.

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

The only items in the file that may be copied by the provider are documents which the provider sent to Molina (e.g., the application, the license and a copy of the DEA certificate). Providers may not copy documents that include pieces of information that

are confidential in nature, such as the provider credentialing checklist, the responses from monitoring organizations (i.e. National Provider Data Bank, State Licensing Board), and verification of hospital privileges letters.

Providers Right to Correct Erroneous Information

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

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

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

- Their requirement to submit a written response within ten (10) calendar days of receiving notification from Molina.
- In their response, the provider must explain the discrepancy, may correct any erroneous information and may provide any proof that is available.
- The provider's response must be sent to Molina Healthcare, Inc., Attention: Credentialing Director, PO Box 2470, Spokane, WA 99210.

Upon receipt of notification from the provider, Molina will document receipt of the information in the provider's credentials file. Molina will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the provider's credentials file. The provider will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with providers, the Credentialing department will notify the provider. The provider may then provide proof of correction by the primary source body to Molina's Credentialing department. The Credentialing department will re-verify primary source information if such documentation is provided.

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

Providers Right to be Informed of Application Status

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

The provider can request to be informed of the status of their application by telephone, email or mail. Molina will respond to the request within two (2) working days. Molina may share with the provider where the application is in the credentialing process to include any missing information or information not yet verified. Molina does not share with or allow a provider to review references or recommendations, or other information that is peer-review protected.

Excluded Providers

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

Pursuant to section 1128 of the SSA, Molina and its Subcontractors may not subcontract with an Excluded provider/person. Molina and its Subcontractors shall terminate subcontracts immediately when Molina and its Subcontractors become aware of such excluded provider/person or when Molina and its Subcontractors receive notice. Molina and its Subcontractors certify that neither it nor its member/provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency. Where Molina and its Subcontractors are unable to certify any of the statements in this certification, Molina and its Subcontractors shall attach a written explanation to this agreement.

Ongoing Monitoring of Sanctions

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

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program** – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- **State Medicaid Exclusions** – Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent).
- **Medicare Exclusion Database (MED)** – Molina monitors for Medicare exclusions through the Centers for Medicare & Medicaid Services (CMS) MED online application site.

- **National Practitioner Database** – Molina enrolls all credentialed practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- **System for Award Management (SAM)** – Monitor for providers sanctioned with SAM.

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

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

13. Risk Adjustment Management Program

What is Risk Adjustment?

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

Why is Risk Adjustment Important?

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

Your Role as a Provider

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

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

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

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

RADV Audits

As part of the regulatory process, CMS conducts Risk Adjustment Data Validation (RADV) audits to ensure that diagnosis data submitted by Molina was accurate. All claims/encounters submitted to Molina are subject to federal and internal health plan auditing. If Molina is selected for a RADV audit, providers will be required to provide medical records to validate the data previously submitted.

Contact Information

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

14. 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 members will have to pay for covered services in a calendar year. The OOPM amount will be specified in the member's 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 will not count toward the OOPM.

The Schedule of Benefits may list an OOPM amount for each individual enrolled and a separate OOPM amount for the entire family when there are two or more members enrolled. When two or more members are enrolled:
(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, Molina will pay one-hundred percent (100%) of the allowable amount for covered services for that individual for the rest of the calendar year. Once the Cost Sharing for two or more members in a family adds up to the family OOPM amount, Molina will pay one-hundred percent (100%) of the allowable amount for covered services for the rest of the calendar year for the family.

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.

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 allowable amount. Coinsurances are listed in the Molina member's Schedule of Benefits. Some covered services do not have coinsurance and may apply a deductible or copayment instead.

Copayment: a specific dollar amount members must pay when they receive covered services. Copayments are listed in the Molina member's Schedule of Benefits. Some covered services do not have a copayment, and may apply a deductible or coinsurance instead.

Cost Sharing: the deductible, copayment, or coinsurance that members must pay for covered services. The Cost Sharing amount members will be required to pay for each type of covered service is listed in the Molina member's 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. Deductibles are listed in the Molina member's Schedule of Benefits.

Please refer to the Molina member's 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.

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.

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 Molina member's 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 ten (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 nineteen (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 twenty-one (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 PCS 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 fourteen (14) years or older.
- Pediatricians, who see children from newborn to age eighteen (18) or twenty-one (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 twenty-one (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: means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb, or permanent health of the injured or ill person, and may include such health care services provided out of the health insuring corporation's approved service area pursuant to indemnity payments or service agreements.