



## **BENEFITS AND COVERED SERVICES**

This section provides an overview of the medical benefits and services covered for Molina Healthcare of Ohio, Inc. members.

### **COVERED SERVICES**

Molina Healthcare ensures that members have access to medically-necessary services covered by the Ohio Medicaid fee-for-service (FFS) program. For information on Medicaid-covered services, refer to the Ohio Department of Medicaid (ODM) website at:

<http://medicaid.ohio.gov/FOROHIOANS/CoveredServices.aspx>.

Services covered by Molina Healthcare include:

- Alcohol and chemical dependency services
- Ambulance and ambulance services
- Annual physicals for adults
- Behavioral health services
- Cardiac rehab
- Chiropractic services
- Chemotherapy
- Dental services (not all inclusive)
- Dialysis
- Durable medical equipment and medical supplies (following Medicaid guidelines)
- Enteral formulas and nutritional supplements
- Family planning services and supplies
- Federally Qualified Health Center/Rural Health Clinic (FQHC/RHC) facilities or Qualified Family Planning Providers (QFPP) services (group is not required to be contracted with Molina Healthcare)
- Freestanding Birth Center (FBC) services contracted with Molina Healthcare to low-risk expectant mothers, as defined in rule [3701-83-33](#) of the Administrative Code
- Genetic counseling and testing
- Health education
- Home health services
- Home infusion
- Hospice and palliative care
- Imaging services
- Immunizations
- Injectable drugs administered in the provider office setting (not all inclusive)
- Inpatient admissions: acute hospital, Long Term Acute Care (LTAC), rehabilitation and Skilled Nursing (SNF)
- Laboratory and x-ray services
- Nurse-midwife, certified family nurse practitioner, and certified pediatric nurse practitioner services
- Outpatient hospital services
- Physical therapy, occupational therapy, and speech therapy

- Physician services furnished in the physician's office, urgent care center, member's home, hospital, or any other ODM approved location
- Podiatry services excluding routine
- Prescriptions
- Respite Care
- Screening, diagnosis, and treatment services to children under the age of 21 under Healthchek, Ohio's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program
- Short-term rehabilitative stays in a nursing facility
- Sleep Studies
- Transplants
- Vision care services, including eyeglasses

### ***Behavioral Health Services***

Molina Healthcare members have direct access to behavioral health services through Community Mental Health Centers (CMHCs) and Ohio Department of Alcohol and Drug Addiction Services (ODADAS)-certified Medicaid providers. Services from CMHC or ODADAS facilities do not require a referral or authorization.

Members who are not able to obtain behavioral health services from CMHC or ODADAS facilities, or who prefer to obtain behavioral health services from a provider other than a CMHC or ODADAS facility, may see mental health and substance abuse providers contracted with Molina Healthcare for covered services. No authorization is required up to 12 office visits for adults ages 21 and older and 20 visits for children ages 0-20 in a calendar year. Contact Molina Healthcare at 1-800-642-4168 to obtain referral information and authorizations for behavioral health services rendered by network providers for additional office visits.

### ***Emergency / Urgent Care Services***

#### ***Emergency Services***

An emergency medical condition is defined as a medical condition manifesting itself by 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 the absence of immediate medical attention to result in any of the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Emergency services include covered inpatient services, outpatient services, or medical transportation provided by a qualified provider needed to evaluate, treat, or stabilize an emergency medical condition.

Molina Healthcare covers emergency services 24 hours a day, seven days a week. At a minimum, such services will be reimbursed in accordance with the following:

- Molina Healthcare does not deny payment for treatment obtained because of an emergency medical condition as defined above.
- Molina Healthcare does not limit what constitutes an emergency medical condition on the basis of a diagnosis list or symptoms.
- Molina Healthcare covers all emergency services without requiring prior authorization.
- Molina Healthcare covers Medicaid-covered services related to the member's emergency medical condition when the member is instructed to go to an emergency facility by a representative of

Molina Healthcare, including but not limited to the member's primary care provider (PCP) or Molina Healthcare's 24-Hour Nurse Advice Line.

- Molina Healthcare does not deny payment for emergency services because the treating provider, hospital, or fiscal representative did not notify the member's PCP of the visit.
- Molina Healthcare will cover emergency services when the services are delivered by a provider not contracted with Molina Healthcare. Such services will be reimbursed by Molina Healthcare at either the Ohio Medicaid rate or the billed amount, whichever is less.
- If an inpatient admission results, Molina Healthcare will reimburse at this rate only if the services are authorized (please see Medical Management chapter for additional details). Molina Healthcare may coordinate a transfer of the member to a participating provider.

Molina Healthcare will adhere to the judgment of the attending physician when requesting a member's discharge or transfer to another facility. Molina Healthcare has established arrangements with hospitals so that Molina Healthcare contracted physicians can assume the attending physician's responsibilities to stabilize, treat and transfer the member.

Molina Healthcare members who have an emergency medical condition cannot be held liable for payment of any subsequent screening and treatment needed to diagnose the specific condition or to stabilize. Molina Healthcare covers post-stabilization care services that a treating physician views as medically necessary in order to maintain the stabilized condition or to improve or resolve the member's condition.

### ***Urgent Care Services***

Services that require immediate medical attention, but are not life threatening, are covered by Molina Healthcare without a referral, including services rendered by non-participating providers outside of Molina Healthcare's service area.

### ***Healthchek***

Healthchek is Ohio's EPSDT program, which includes federally-mandated health services for Medicaid-eligible persons, birth through age 20. EPSDT is designed to promote health by providing early intervention to diagnose and treat health issues (Ohio Administrative Code 5160-14-01). All Healthchek services are covered benefits under Molina Healthcare of Ohio.

Molina Healthcare is required by OAC 5160-26-05.1(A)(13) to provide its contracted providers with a description of the Healthchek services to be provided to Medicaid members. In addition, OAC 5160-26-03 (H)(121)(b) requires that providers contracted with Molina Healthcare of Ohio notify their patients/parents or guardians of their patients of the appropriate Healthchek services and exam intervals.

The Healthchek program is summarized below. Please be sure to communicate the need for and recommended timing of Healthchek services to your patients or parent/guardian of your patients. Please refer to OAC 5160-14-01 through 5160-14-05 for detailed information regarding the Healthchek program.

Providers eligible to provide Healthchek services:

- Physicians
- Advanced Practice Nurses (APNs)
- Vision Service Providers
- Dental Service Providers
- Clinic Service Providers

Screening components of the Healthchek (EPSDT) program are defined in the American Academy of Pediatrics (AAP) [recommendations for preventive pediatric health care](#) and can be found at [www.aap.org](http://www.aap.org). Additional preventive care guidelines and Healthchek-EPSDT screening forms are available at [www.molinahealthcare.com](http://www.molinahealthcare.com) by selecting the Health Resources tab and Guidelines.

In accordance with OAC 5160-14-03, Covered Healthchek (EPSDT) Screening Services, the screenings detailed below shall be completed and documented unless the patient or parent/guardian of the patient refuses the service. Be sure to document any service that is refused.

The following screenings are required at the appropriate screening intervals:

- Comprehensive health and developmental history
- Comprehensive physical examination
- Developmental screening (including physical and mental health development)
- Nutritional screening
- Vision screening
- Hearing screening
- Immunization screening
- Lead toxicity screening
- Laboratory tests (as determined appropriate by the primary health care provider)
- Dental screening
- Health education, counseling, anticipatory guidance and risk factor reduction interventions
- Referral for evaluation, diagnosis and/or treatment when screening visit indicates need for further evaluation

Coding requirements for Healthchek services can be found in OAC 5160-14-04.

Providers are required to make a timely referral for diagnosis and/or treatment when a screening exam indicates the need for further evaluation of the patient's health. Evaluation, diagnosis and/or treatment may be provided at the time of the screening visit if the provider is qualified to provide the following services.

- Vision services
- Hearing services
- Dental services
- Interperiodic exams, vision, hearing, and dental services necessary to determine the existence of physical or mental illnesses or conditions
- Diagnostic and treatment services for patients under 21 to treat or ameliorate a defect, physical or mental illness or condition

### ***Home Health Services***

- Per OAC 5160-12-01, a face-to-face encounter with the qualifying treating physician must be done 90 days prior to start of care or within 30 days following the start of care. The treating physician must complete a [certificate of medical necessity](#) (CMN), Form JFS 07137, documenting this visit and the reasons for requesting home care.
- The first three Home Health Skilled visits do not require a prior authorization for Medicaid members who meet the ODM CMN requirements.
- Requests for prior authorization of this service must be accompanied by the CMN form (JFS 07137).

### ***Home Health Services for Mom and Baby after Delivery***

- Mom and baby can have up to two home health care visits (G0154), within the baby's first 28 days of life only without a prior authorization, provided the appropriate diagnosis code(s) are billed on the claim(s).
- Refer to the Claims and Encounters Data section of this manual for modifier and diagnosis code requirements.

### **Respite Care**

Respite care is the provision of short-term, temporary relief to those who are caring for family members who might otherwise require permanent placement in a facility outside the home.

The service provides general supervision, meal preparation and hands-on assistance with personal care that are incidental to supervision during the period of service delivery. Respite services can be provided on a planned or emergency basis and shall only be furnished at the primary place of residence. The provider of respite care must be awake during the provision of respite services and the services shall not be provided overnight.

- Respite services are limited to no more than 24 hours per month and 250 hours per year.
- Respite services **must** be provided by enrolled Medicaid providers who meet the qualifications of the program, including a competency evaluation program and first-aid training. Respite services must not be delivered by the child's legally responsible family member or foster caregiver. (OAC 5160-26-3)

All of the following criteria is required to be met in order to qualify for the benefit:

- The member must reside with his or her informal, unpaid primary caregiver in a home or an apartment that is not owned, leased or controlled by a provider of any health-related treatment or support services.
- The member must not be residing in foster care.
- The member must be under the age of twenty-one and determined eligible for social security income for children with disabilities or supplemental security disability income for adults disabled since childhood.
- The member must be enrolled in the MCP's care management program.
- The member must be determined by the MCP to meet an institutional level of care as set forth in rules 5160-3-07 and 5160-3-08 of the Administrative Code.
- The member must require skilled nursing or skilled rehabilitation services at least once per week.
- The member must have received at least fourteen hours per week of home health aide services for at least six consecutive months immediately preceding the date respite services are requested.
- The MCP must have determined that the child's primary caregiver has a need for temporary relief from the care of the child as a result of the child's long term services and support needs/disabilities, or in order to prevent the provision of institution or out-of-home placement.

### ***Immunizations***

Immunizations are covered when administered in accordance with rule 5160-4-12 of the Administrative Code.

Designated free vaccines for individuals eighteen years of age or younger are listed on the [Provider Administered Pharmaceuticals](#) Fee Table in column “Coverage Under the VFC Program (federal “Vaccines for Children”).

- Providers of Medicaid services who enroll and agree to immunize eligible children in their medical practice or clinic, obtain designated free vaccines from the Ohio Department of Health (ODH) at no charge.
  - Reimbursement for the administration fee of these designated free vaccines must be billed using the appropriate codes listed in the Provider Administered Pharmaceuticals Fee Table and will be paid as described in paragraph (G)(2) of rule 5160:4-12 of the Administrative Code. The actual administration code is not payable.
- Covered vaccines for individuals nineteen years of age or older are listed on the Provider Administered Pharmaceuticals Fee Table in column “Medicaid Maximum Fee or Coverage Status” . These immunizations are not designated as free vaccines.
    - Providers who administer covered non-designated vaccines identified on the Provider Administered Pharmaceuticals Fee Table may be reimbursed the Medicaid maximum amount listed or the lesser of the provider’s billed charge for each immunization provided.

### ***Prenatal Risk Assessment***

Molina Healthcare will reimburse providers for a prenatal risk assessment (PRA) by completing the appropriate PRA form. The PRA form is a checklist of medical and social factors used as a guideline to determine when a patient is at risk of a preterm birth or poor pregnancy outcome. Both the [Molina Healthcare PRA form](#) and the [JFS 03535](#) PRA form will be accepted. The PRA form must be completed on each obstetrical patient during the initial antepartum visit in order to bill for the prenatal at-risk assessment code.

Coding requirements for a PRA can be found in OAC 5160-4-10.

### ***Prescription Drugs***

Molina Healthcare will pay for medically necessary prescription drugs and certain medical supplies, dispensed by a pharmacy (diabetic supplies, inhaler spacers, peak flow meters, syringes, needles, alcohol wipes, and condoms).

Payment will only be made for those covered by Ohio Medicaid obtained from pharmacies and medical equipment suppliers contracted with Molina Healthcare. A complete list of participating providers is available in the Molina Healthcare online provider directory at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com), or you can call Molina Healthcare Provider Services for assistance at 1-855-322-4079.

Please follow the guidelines as referenced in Molina Healthcare’s Preferred Drug List (PDL) available at [Drug Formulary](#) and [Ohio Medicaid Supply List, 5160-10-03 - Appendix A](#) for limits and prior authorization requirements.

### **24-HOUR NURSE ADVICE LINE**

The 24-Hour Nurse Advice Line is available to all Molina Healthcare members. Members may call 1-888-275-8750 or 1-866-648-3537 (Español) (For the hearing impaired, call TTY 1-866-735-2929), any time they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, 7 days a week to assess the member’s symptoms and help them make good health care decisions.

The registered nurses at the 24-Hour Nurse Advice Line will assess the member's symptoms and guide the patient to the most appropriate place for care (they do not diagnose). The Nurse Advice Line may refer the member to his or her PCP, a specialist, 911 or the emergency department. Educating members about the appropriate place for care reduces costs and pressure on the health care system.

### **COVERAGE OF MEDICALLY-NECESSARY SERVICES**

If a member is unable to obtain medically-necessary Medicaid-covered services from a Molina Healthcare network provider, then the services will be covered out of network until Molina Healthcare is able to provide the services from a network provider.

### **SECOND OPINIONS**

At the member's request, Molina Healthcare will provide for a second opinion from a qualified health care professional within the Molina Healthcare panel. Molina Healthcare Member Services will assist the member with arranging for this service. If a qualified health care professional is not available within Molina Healthcare's panel, Molina Healthcare will arrange for the member to obtain a second opinion outside the panel.

### **SELF-REFERRALS**

Molina Healthcare members can self-refer for the following:

- Services provided at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).
- Family planning services provided by Qualified Family Planning Providers (QFPPs).
- Services provided by Certified Nurse Practitioners (CNPs)
- Services provided by Certified Nurse Midwives (CNMs)
- Women's routine and preventative health care services provided by any women's health specialist contracted with Molina Healthcare. This is in addition to the member's designated primary care provider (PCP) if that PCP is not a woman's health specialist.
- Behavioral health services offered through Community Mental Health Centers (CMHCs).
- Substance abuse services offered through Ohio Department of Alcohol and Drug Addiction Services (ODADAS)-certified Medicaid providers.

### **EXCLUSIONS AND LIMITATIONS**

Some services and procedures are excluded, or are covered on a limited basis. The following is a general list of the services not covered by Molina Healthcare:

- Services or supplies that are not medically necessary
- Experimental services and procedures, including drugs and equipment, not covered by Medicaid
- Organ transplants that are not covered by Medicaid
- Abortions, except in the case of a reported rape, incest, or when medically necessary to save the life of the mother (see clarification below)
- Infertility services for males or females
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure (see clarification below)
- Reversal of voluntary sterilization procedures

- Cosmetic surgery that is not medically necessary\* (see clarification below)
- Immunizations for travel outside of the United States
- Services for the treatment of obesity unless medically necessary\* (see clarification below)
- Custodial or supportive care
- Sex change surgery and related services
- Sexual or marriage counseling
- Court ordered testing
- Acupuncture and biofeedback services
- Services to find cause of death (autopsy)
- Comfort items in the hospital (e.g., TV or phone)
- Paternity testing

### ***Abortion, Hysterectomy and Sterilization***

Molina Healthcare's policy on abortion, hysterectomy and sterilization services is in compliance with ODM rules and regulations. Molina Healthcare has implemented internal procedures, including system edits, to ensure that claims are paid only if the required criteria are met and the appropriate forms are submitted.

In compliance with the Ohio Administrative Code, Molina Healthcare reimburses abortion services only in the following circumstances:

- Instances in which the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.
- Instances in which the pregnancy was the result of an act of rape and the patient, the patient's legal guardian or the person who made the report to the law enforcement agency, certifies in writing that a report was filed, prior to the performance of the abortion, with a law enforcement agency having the requisite jurisdiction, unless the patient was physically unable to comply with the reporting requirement and that fact is certified by the physician performing the abortion.
- Instances in which the pregnancy was the result of an act of incest and the patient, the patient's legal guardian or the person who made the report certifies in writing that a report was filed, prior to the performance of the abortion, with either a law enforcement agency having the requisite jurisdiction, or, in the case of a minor, with a county children services agency, unless the patient was physically unable to comply with the reporting requirement and that fact is certified by the physician performing the abortion.

Per the Ohio Administrative Code, forms must be completed for abortions, hysterectomies and sterilizations:

- JFS 03197 - Abortion Certification Form
- JFS 03199 - Consent to Hysterectomy
- HHS-687 or HHS-687-1 (Spanish version) - Consent to Sterilization

These forms are available at [www.hhs.gov](http://www.hhs.gov) or [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com) by selecting the Forms tab.

### ***Abortion***

Before reimbursement for an abortion can be made, the service must be prior authorized, and the provider performing the abortion must certify that one of the three circumstances listed above has occurred. Requests for prior authorization of this service must be accompanied by the ODM Abortion Certification Form (JFS 03197). The physician's signature must be in the physician's own handwriting. All



certifications must contain the name and address of the patient. Documentation that supports the certification made by the physician must be maintained by the physician in the recipient's medical record.

Reimbursement will not be made for associated services such as anesthesia, laboratory tests, or hospital services if the abortion service itself cannot be reimbursed. This policy does not deny reimbursement for drugs or devices to prevent implantation of the fertilized ovum, or for medical procedures for the termination of an ectopic pregnancy nor does it apply to those abortions which are treatments for incomplete, missed, or septic abortions.

### ***Hysterectomy***

Payment will only be made for those hysterectomies performed for medical reasons, such as a diseased uterus, and only if the recipient has been advised orally and in writing prior to surgery that sterility will result. Reimbursement will not be made for hysterectomy procedures done with the primary intent of fertility control. Reimbursement will not be made for associated services when the hysterectomy itself is not eligible for reimbursement.

Hysterectomies must be prior authorized, and all requests for this service must be accompanied by a completed Consent to Hysterectomy Form (JFS 03199). Payment cannot be made for a hysterectomy without obtaining signed acknowledgment of the hysterectomy consent form except in the following circumstances:

- The individual was already sterile before the hysterectomy; or
- The individual was postmenopausal; or
- The individual requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgment is not possible.

The provider may sign and date the consent to sterilization form either before or after the date the procedure is performed. The primary provider performing the hysterectomy is normally responsible for securing the recipient's informed consent for the procedure; however, if a members changes providers, it is not necessary for the second provider to obtain another consent form.

### ***Sterilization***

Molina Healthcare will reimburse sterilization procedures only if the following requirements are met:

- The service has been prior authorized.
- The sterilization is the result of a voluntary request by a recipient legally capable of consenting to such a procedure.
- The individual is at least twenty-one years old at the time consent is obtained.
- The individual is not mentally incompetent. A mentally incompetent individual is a person who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.
- The individual is not institutionalized.
- The individual has been given a thorough explanation of all elements of the Consent to Sterilization Form prior to giving consent for the procedure to be performed.
- Payment will be made for sterilization without obtaining signed acknowledgment of the sterilization consent form in unique circumstances of an unscheduled clinical event that requires sterilization because of a life-threatening emergency situation in which the physician determines that prior acknowledgment is not possible.

All prior authorization requests for sterilizations must include a copy of the signed consent form. The date the physician signs the form cannot be prior to the date that the recipient signs the form. Informed consent

must **not** be obtained while the individual to be sterilized is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substances that affect the individual's state of awareness. At least 30 days, but not more than 180 days may pass between the date of the informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery.

The recipient must be made fully aware that he/she is free to withhold consent to the procedure at any time before the sterilization, without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled. In instances where the individual is blind, deaf, or otherwise handicapped, arrangements must be made to ensure that all information is effectively communicated. Similarly, an interpreter must be provided if the individual to be sterilized did not understand the language of the consent form or of the person obtaining the consent.

An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least seventy-two hours have passed since consent for the sterilization was given. In the case of premature delivery, the informed consent must have been given at least thirty days before the expected date of delivery. The waiver does not apply to cases of unanticipated abortions, since, unlike situations involving emergency abdominal surgery or premature delivery, an abortion in the first trimester of pregnancy is not generally considered a major surgical procedure with consequent double exposure to the risks of major surgery.

#### ***Cosmetic or Reconstructive Surgery***

Plastic or cosmetic surgery is not covered when surgery is performed for aesthetic purposes, including, but not limited to: rhinoplasty, ear piercing, mammary augmentation or reduction, tattoo removal, excision of keloids, fascioplasty, osteoplasty (prognathism and micrognathism), dermabrasion, skin grafts, lipectomy, and blepharoplasty. If medical complications or conditions in addition to the physical imperfection are present, these services could be deemed medically necessary.

#### ***Treatment of Obesity***

Gastroplasty, gastric stapling, or ileo-jejunal shunt could be deemed medically necessary if medical complications or conditions, in addition to the obesity, are present.

#### ***Provider Services***

Call Molina Healthcare Provider Services at 1-855-322-4079 with questions about benefits and covered services.