Provider Orientation

2024

MOLINA® HEALTHCARE

You Matter to Molina

Provider Relations Team

MOLINA® HEALTHCARE

You Matter to Molina

Provider Relations Team: What We Do

The Molina Healthcare of South Carolina Provider Relations Team is available to provide information about our business partnerships, quality initiatives and more.

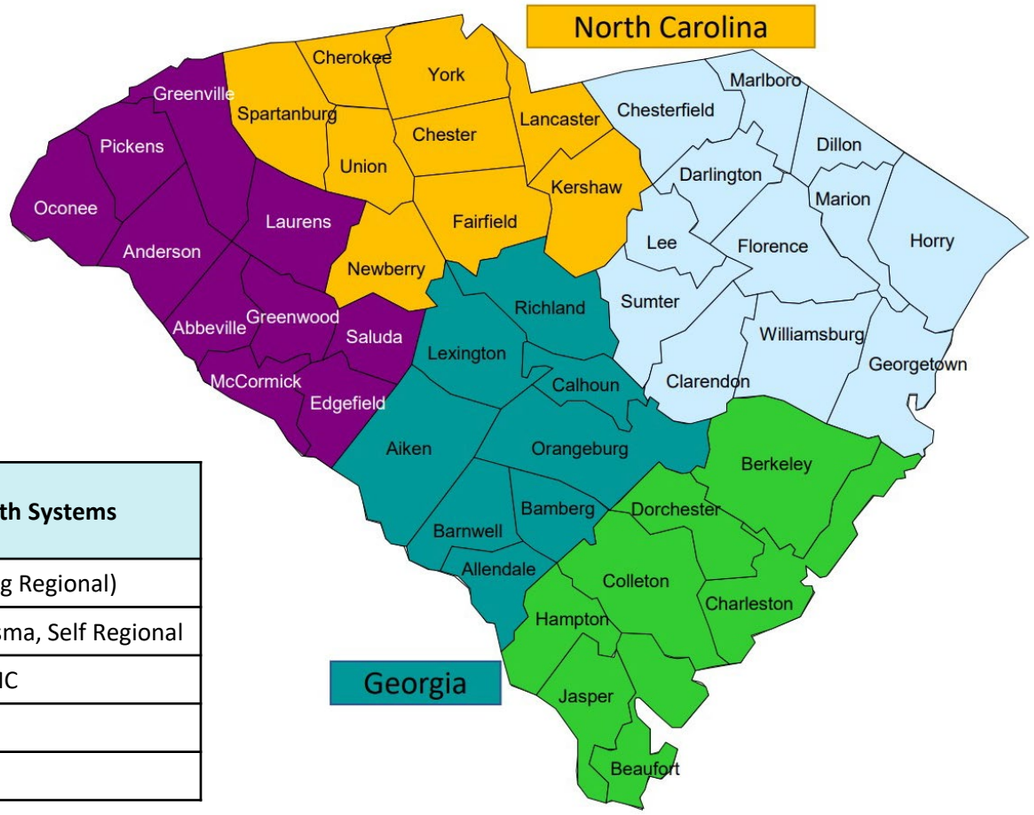
Here's just *some* of what we do…

- Conduct virtual trainings
- Provide resources to assist you with managing patient care
- Offer guidance with provider enrollment, contracting, and demographic updates
- Host community engagement events
- Solicit feedback through an annual provider satisfaction survey
- Serve as a direct contact to assist with escalated issues
- Create provider newsletters, announcements and more

Provider Relations Team: Know Your Representative

Each representative has a designated provider territory. Some specific specialties and health systems have a singular representative, regardless of where the group is located. Please refer to the table for details.

Tyler Stalvey, Director of Provider Relations
Tyler.Stalvey@molinahealthcare.com



Representative	Contact Information		Designated Specialties and/or Health Systems
	Email	Telephone	
Talitha Hampton	Talitha.Hampton@molinahealthcare.com	(803) 440-2700	Atrium, Newberry, RHP (Spartanburg Regional)
Tamequa Durant	Tamequa.Durant@molinahealcare.com	(803) 508-4468	AnMed, Abbeville, Bon Secours, Prisma, Self Regional
Bethany Cook	Bethany.Cook@molinahealthcare.com	(803) 465-7771	Aiken, AU, FHQCs, Home Health, LMC
Contessa Struckman	Contessa.Struckman@molinahealthcare.com	(803) 772-3681	HCA, McLeod, Tidelands
Jen Hamilton	Jennifer.Hamilton2@molinahealthcare.com	(803) 394-1271	MUSC, Roper, Tenet, Uniphy, SNFs

Molina Healthcare, Inc. Products

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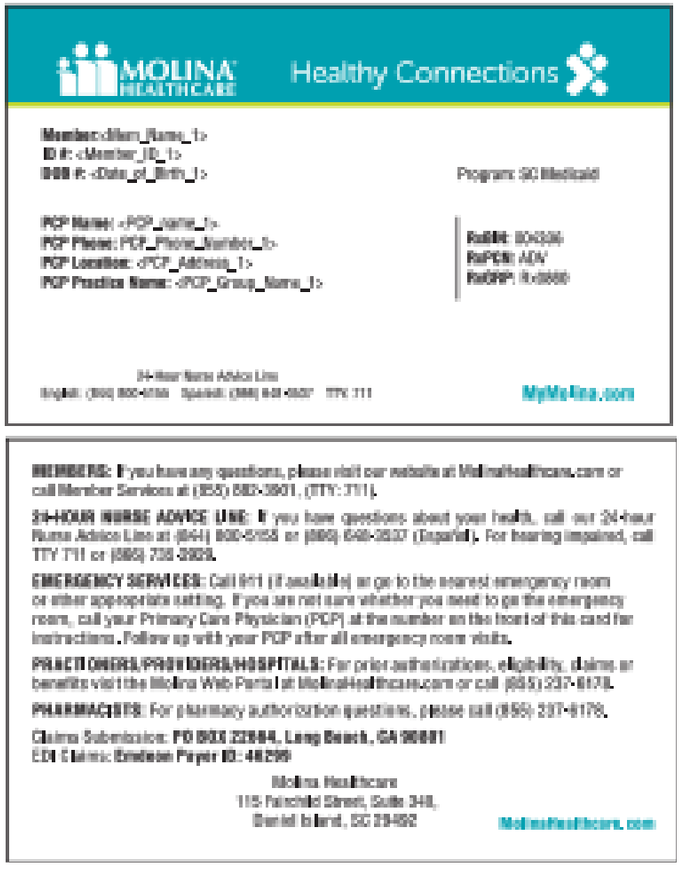
Molina Healthcare, Inc. Products

Molina offers four different products. Each product consists of a unique network of providers and offers various coverage options to eligible members.

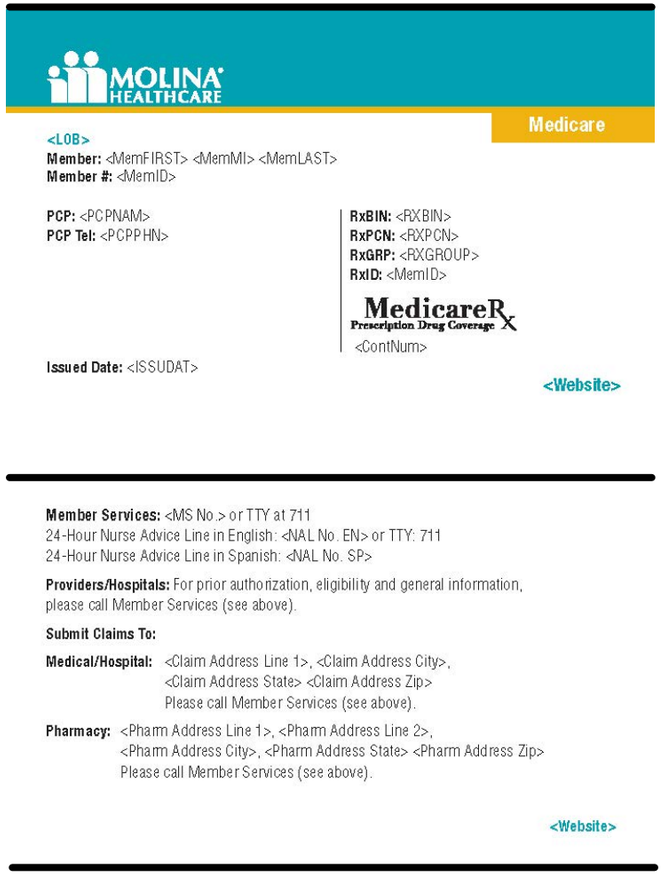
- **Medicaid –** Medicaid is a State and Federal program, which helps pay for health care services for individuals who qualify. Molina members can get what's covered under the Health Connections program and more. Extra benefits are available to eligible Molina members at no cost.
- **Medicare Advantage –** Molina's Medicare Advantage and Prescription Drug plans are designed for beneficiaries who are eligible for Medicare Part A and B . These plans offers all services covered by Original Medicare Parts A and B, prescription drug coverage, and more.
- **Dual Options Medicare-Medicaid Plan (DSNP or MMP) –** The Dual Options plans were designed for beneficiaries who are eligible for both Medicare and Medicaid (dual eligible). These plans offers all services covered by Original Medicare Parts A and B, prescription drug coverage, and more. Plans coordinates benefits of Medicare and Medicaid in order to provide quality health care coverage and service with little out-of-pocket costs.
- **Marketplace** – Molina's Marketplace plans are available for enrollment through the Health Insurance Marketplace® at www.HealthCare.gov or directly from Molina.

Molina Healthcare: Medicaid and Medicare Advantage

Medicaid

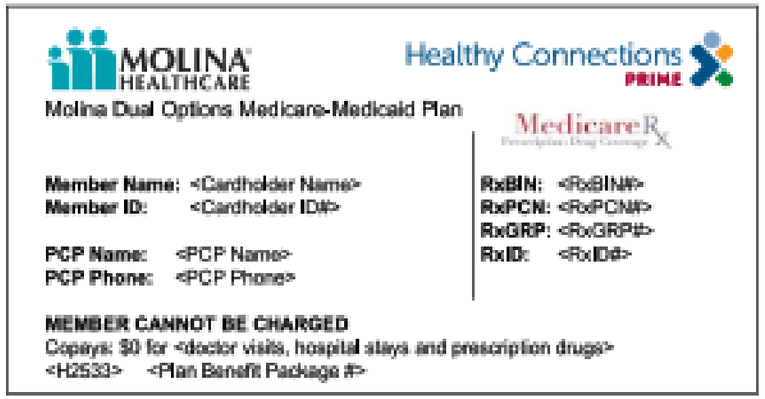


Medicare



Molina Healthcare: Molina Dual Options (MMP) and Marketplace

Molina Dual Options



MOLINA HEALTHCARE

Healthy Connections PRIME

Molina Dual Options Medicare-Medicaid Plan

Medicare Rx Prescription Drug Coverage

Member Name: <Cardholder Name>
Member ID: <Cardholder ID#>

PCP Name: <PCP Name>
PCP Phone: <PCP Phone>

RxBIN: <RxBIN#>
RxPCN: <RxPCN#>
RxGRP: <RxGRP#>
RxID: <RxID#>

MEMBER CANNOT BE CHARGED
Copays: $0 for <doctor visits, hospital stays and prescription drugs>
<H2533> <Plan Benefit Package #>

Carry this card with you at all times and present it each time you receive a service from your doctor, pharmacy, dentist, etc.

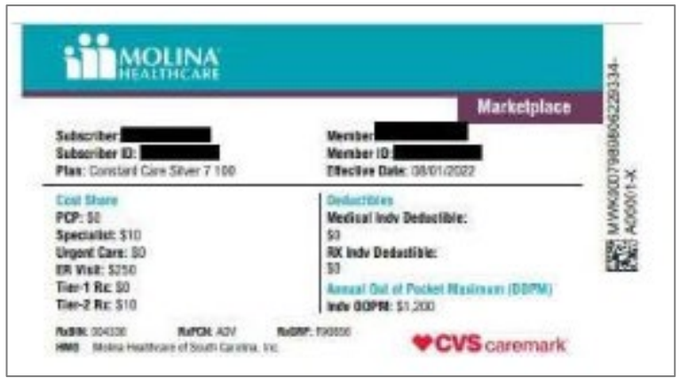
Member Services: <(855) 735-5831>TTY: <711>
Behavioral Health: <(888) 275-8750>
Pharmacy Help Desk: <(866) 693-4620>
Nurse Advice Line: <(888) 275-8750>
Website: <MolinaHealthcare.com/Duals>

Send Claims To: <P.O. Box 22864, Long Beach, CA 90801
EDI Submissions: Payer ID 46299>
Claim Inquiry: <(855) 735-5831>

Marketplace members **do not** have out of network benefits, *except* in the event of an emergency.

Members must receive care from in network providers.

Marketplace



MOLINA HEALTHCARE

Marketplace

Subscriber: [redacted]
Subscriber ID: [redacted]
Plan: Constant Care Silver 7 100

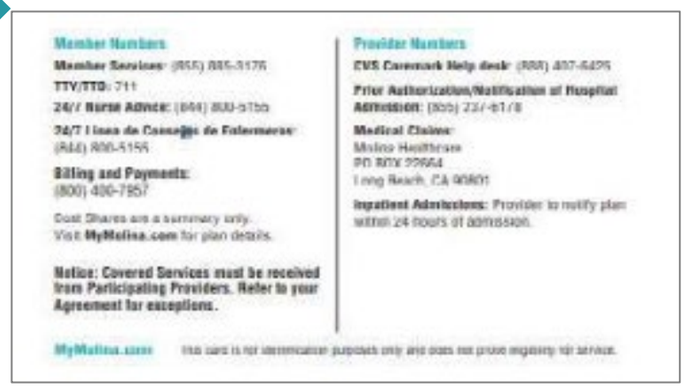
Member: [redacted]
Member ID: [redacted]
Effective Date: 08/01/2022

Cost Share
PCP: $0
Specialist: $10
Urgent Care: $0
ER Visit: $250
Tier-1 Rx: $0
Tier-2 Rx: $10

Deductibles
Medical Ind Deductible: $0
RX Ind Deductible: $0
Annual Out of Pocket Maximum (OOPM)
Ind OOPM: $1,200

RxBIN: 004336 RxPCN: ADV RxGRP: RX0000
HMO Molina Healthcare of South Carolina, Inc.

CVS caremark



Member Numbers
Member Services: (855) 665-5176
TTY/TTD: 711
24/7 Nurse Advice: (844) 800-5155
24/7 Línea de Consejos de Enfermeros: (844) 866-5155
Billing and Payments: (800) 400-7957

Cost Shares are a summary only. Visit MyMolina.com for plan details.

Notice: Covered Services must be received from Participating Providers. Refer to your Agreement for exceptions.

MyMolina.com This card is for identification purposes only and does not prove eligibility for service.

Provider Numbers
CVS Caremark Help desk: (888) 867-6405
Prior Authorization/Notification of Hospital Admission: (800) 224-6178
Medical Claims: Molina Healthcare PO BOX 22864 Long Beach, CA 90801
Inpatient Admissions: Provider to notify plan within 24 hours of admission.

Model of Care Training

Molina Model of Care is the plan for delivering coordinated care and care management to special needs members and provides the basic framework under which we meet the regulatory requirements as defined by CMS.

- Molina Healthcare requires compliance with provider education and training programs.
- All contracted Medicare PCPs and key high-volume specialists are required to complete. Model of Care training annually.

Access the 2024 training here

Complete the attestation here

Molina Websites

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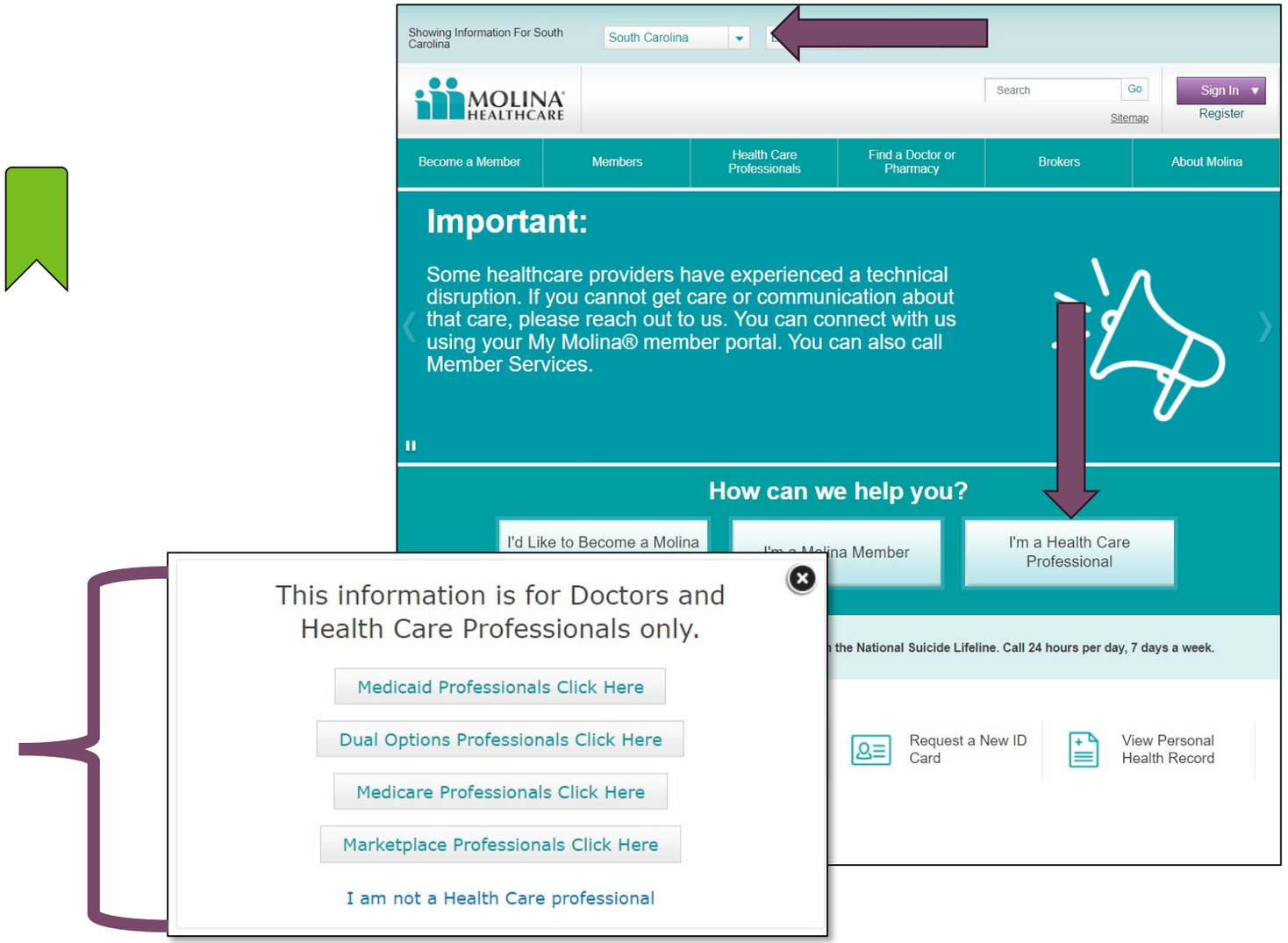
Molina Websites: Landing Page

Molina Healthcare Website

1. Bookmark or save to your favorites
2. Select “South Carolina” from the drop-down box at the top of the page
3. Select “I’m a Health Care Professional”
4. Select the applicable network/plan

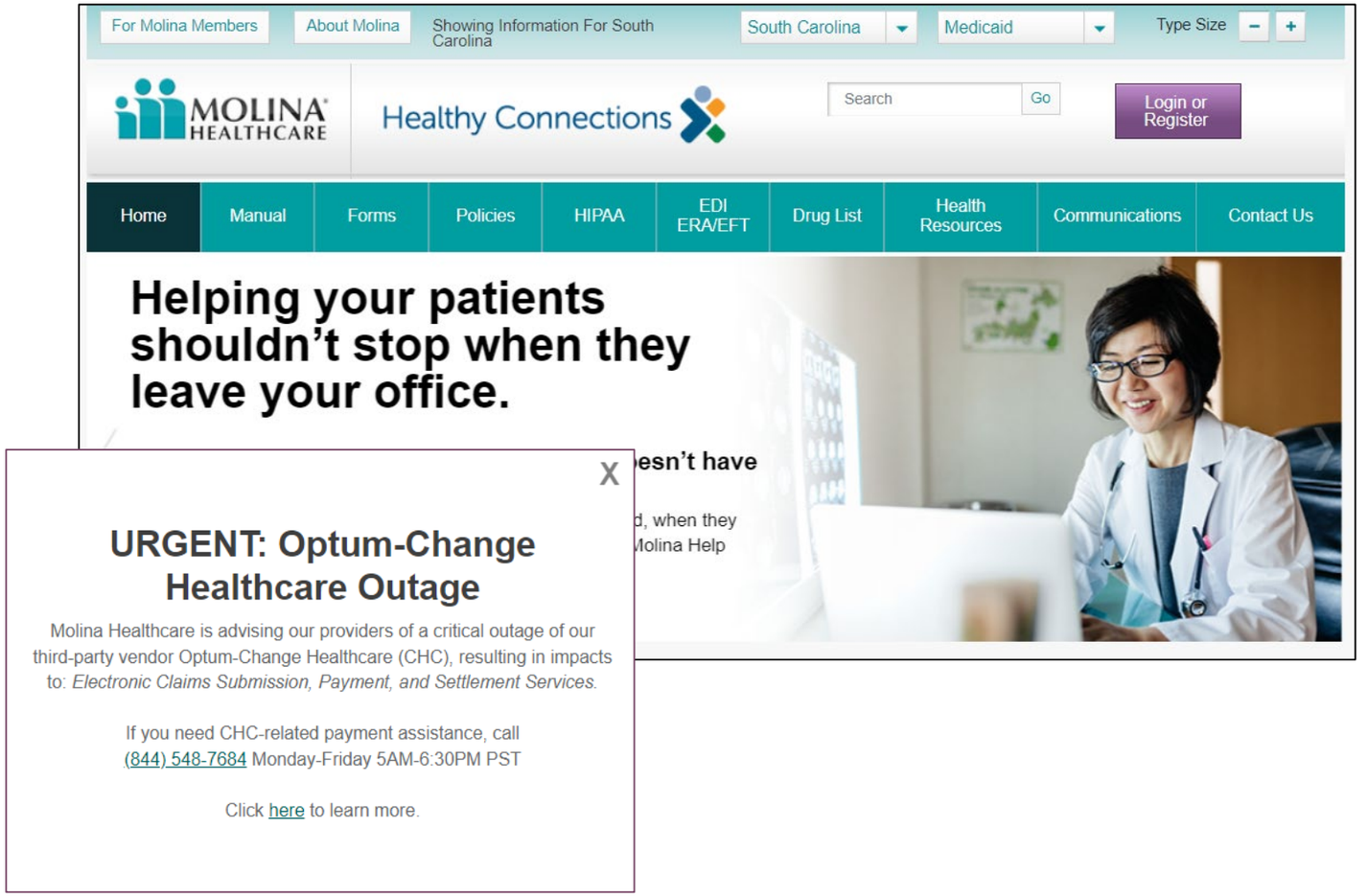


Molina Websites: Provider Home Page

Once you arrive on the Provider Home Page, pay attention to any urgent messages that appear.

As you can see, there is an urgent message regarding the Optum-Change Healthcare outage that occurred in February.

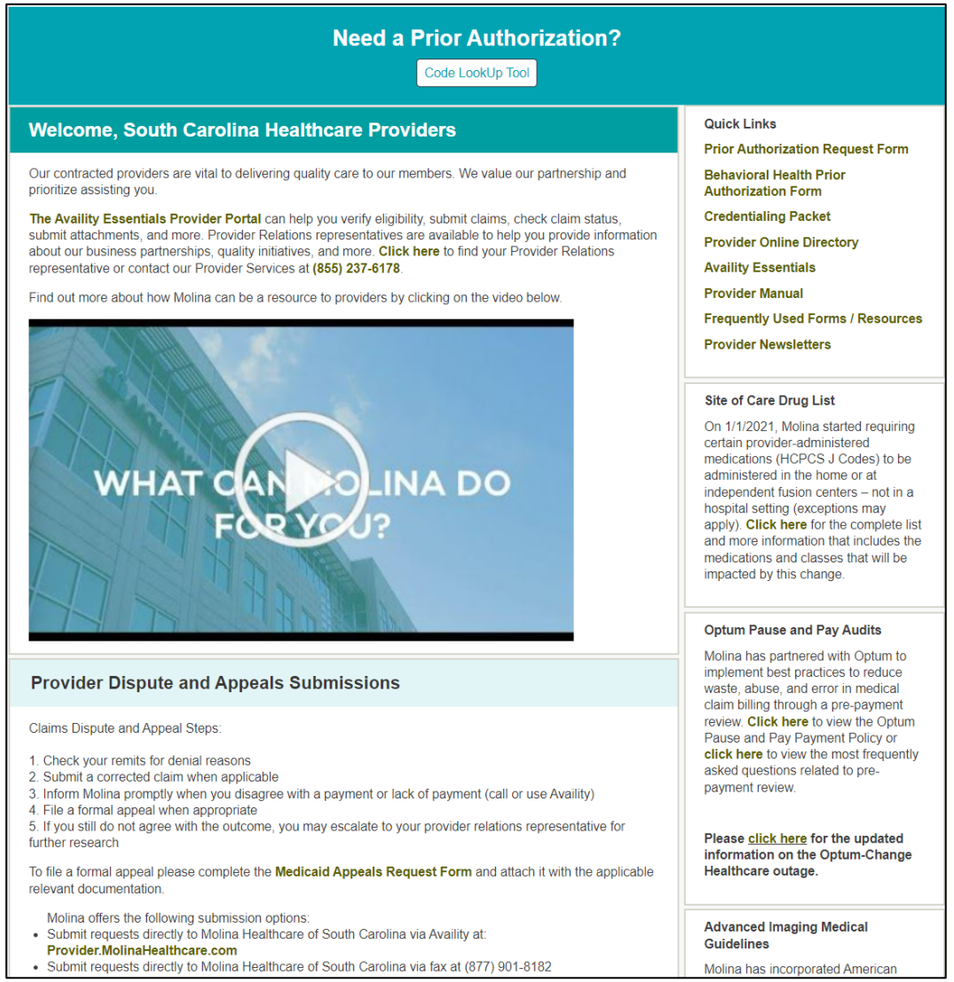
This temporary message includes a link to additional information and resources.



Molina Websites: Provider Home Page

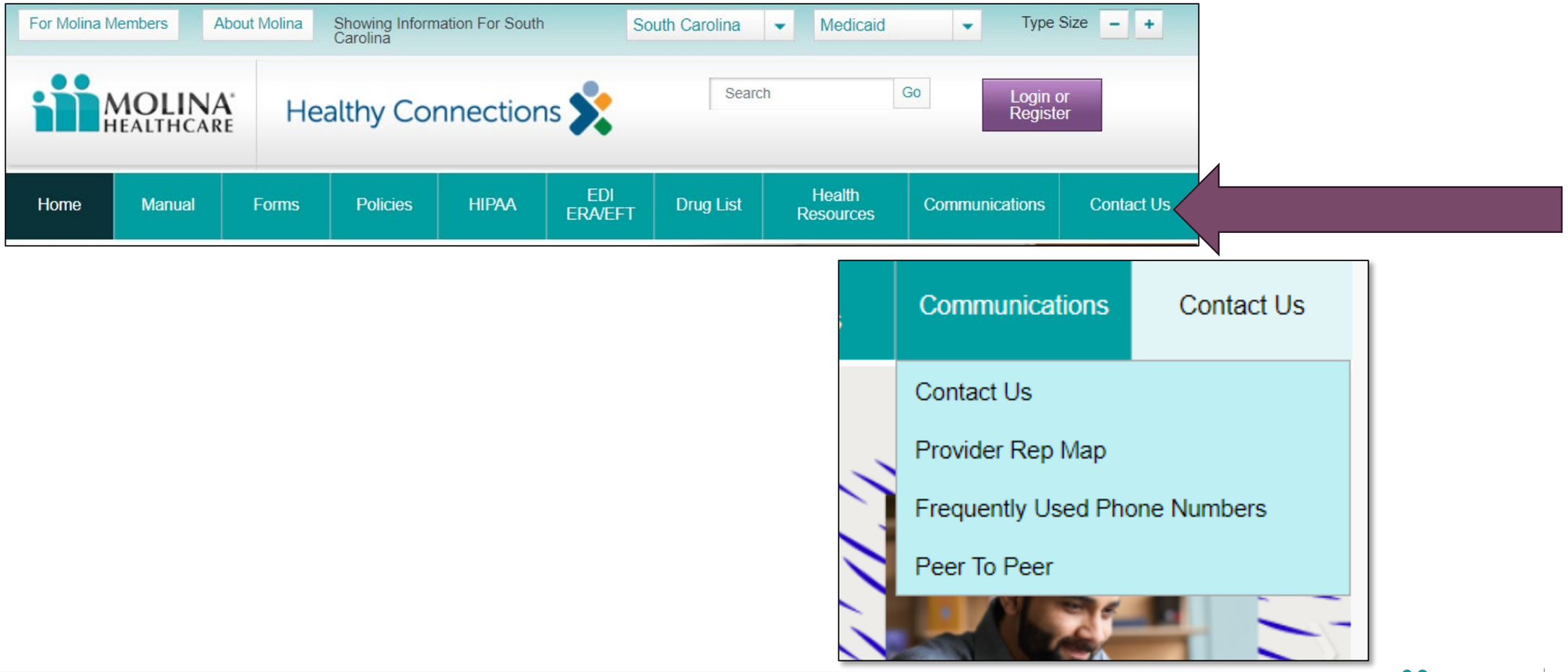
Below the header of the page, you'll see that the body of the home page has links to some of the most used tools and resources:

- Prior Authorization Code LookUp Tool
- Quick Links
  - Prior Authorization Request Form
  - Behavioral Health Prior Authorization Form
  - Credentialing Packet
  - Provider Online Directory
  - Availity Essentials (our secure Provider Portal)
  - Provider Manual
  - Frequently Used Forms / Resources
  - Provider Newsletters (Register for the **Palmetto Partners** and **Partners in Care** newsletters)
- Site of Care Drug List
- Optum Pause and Pay Audit Information
- Advanced Imaging Medical Guidelines
- Provider Changes Information
- Provider Dispute and Appeals Submissions Information



Molina Websites: Provider Home Page

Find the information you need by exploring the options across the top of the page.

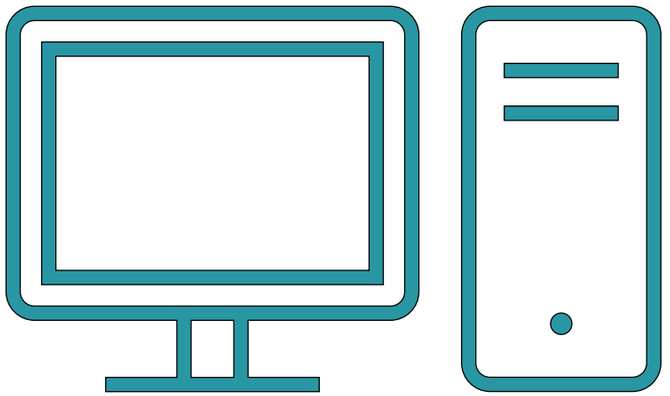


Molina Websites: Provider Resources

Other resources you'll find within the Provider Pages of the website:

- Provider Manual
- Claims Reconsideration Form
- Clinical Policies
- Payment Integrity Policies
- HIPAA Resource Center
- Clearinghouse Information

- Enrollment Information for Electronic Remittance Advice (ERA) or Electronic Funds Transfer (EFT)
- Quality Improvement
- Clinical Practice Guidelines
- Culturally and Linguistically Appropriate Resources/Disability Resources

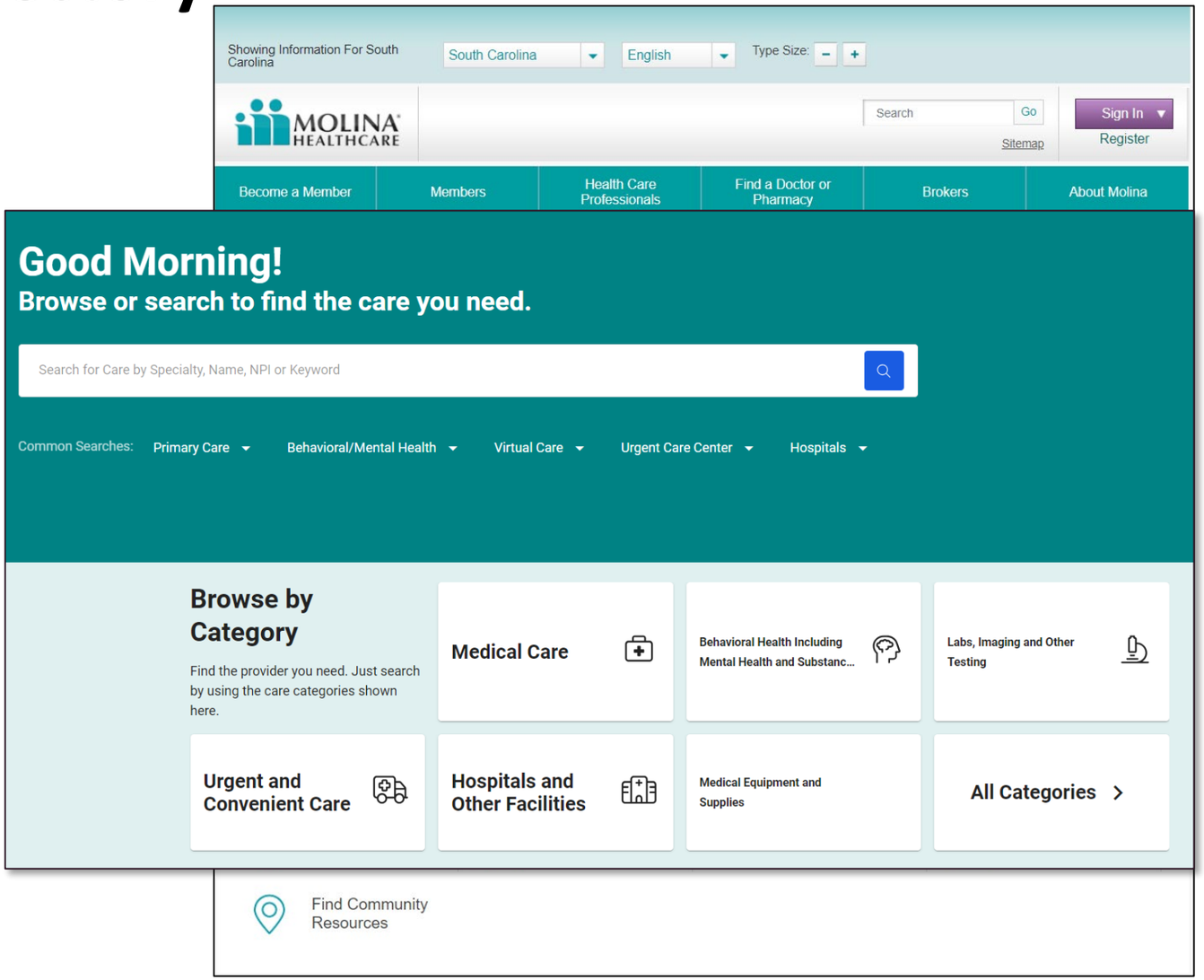


Molina Websites: Provider Directory

The Provider Directory is a tool that offers members a searchable, customizable listing of network participating providers.

Members can search by specialties (categories) and filter results on other criteria:

- People and/or Places (practitioner or group)
- Practitioner Gender
- Expertise
- Specific Services Offered
- Distance
- Accepting New Patients

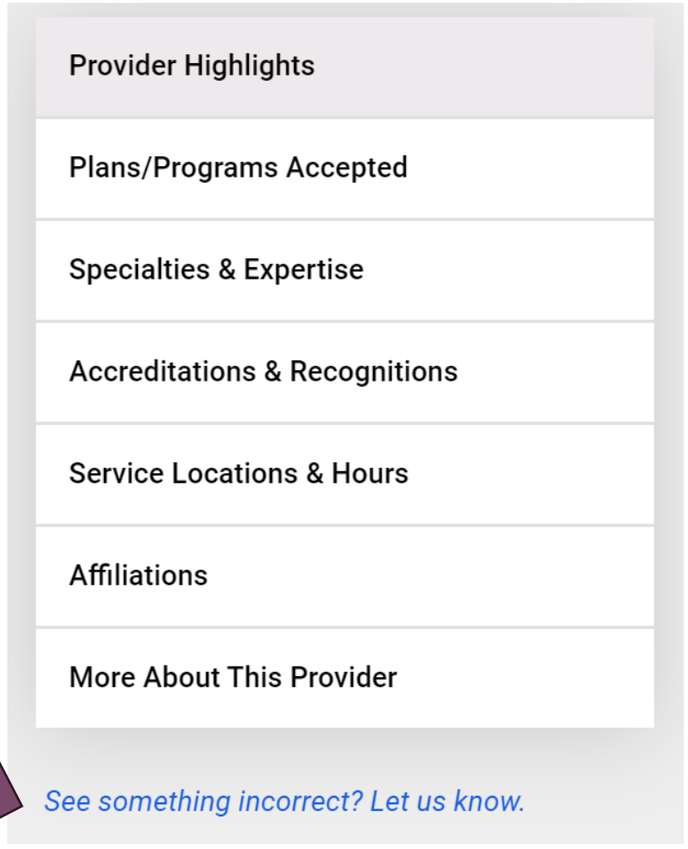


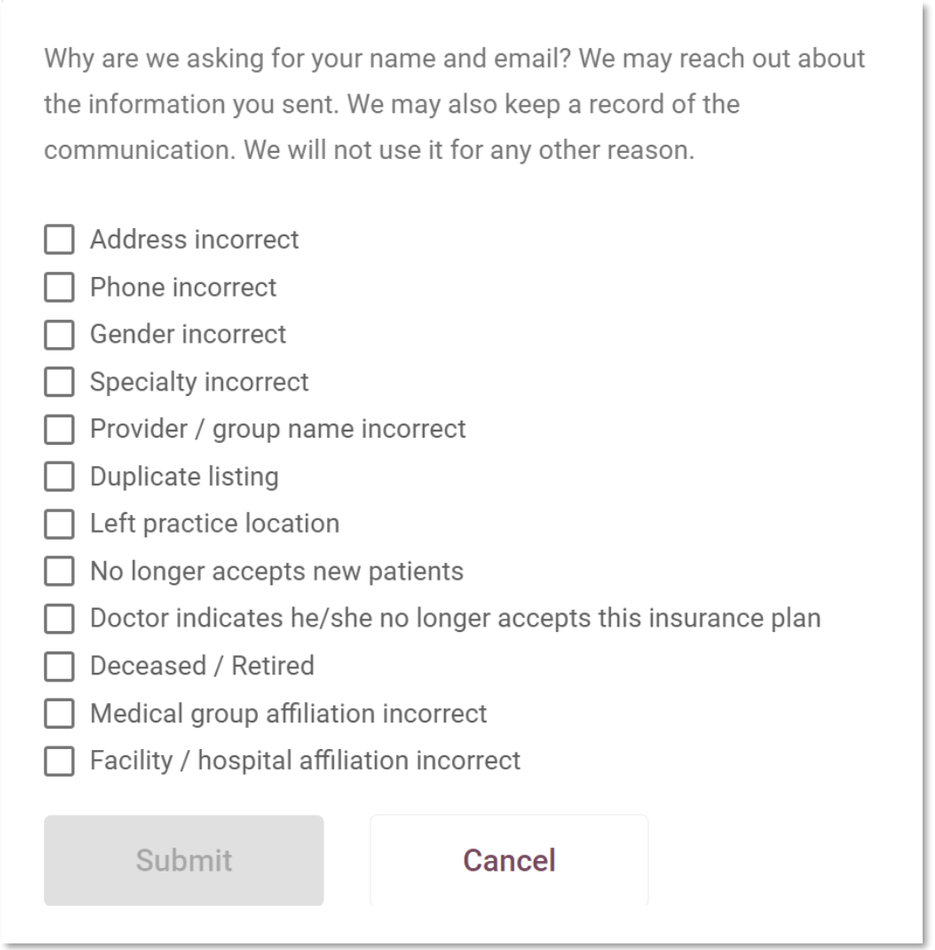
Molina Websites: Provider Directory

Providers are encouraged to use the tool, as well.

Find other network participating providers to refer members.

Review information for your practice or group and report inaccuracies.





Other Online Tools

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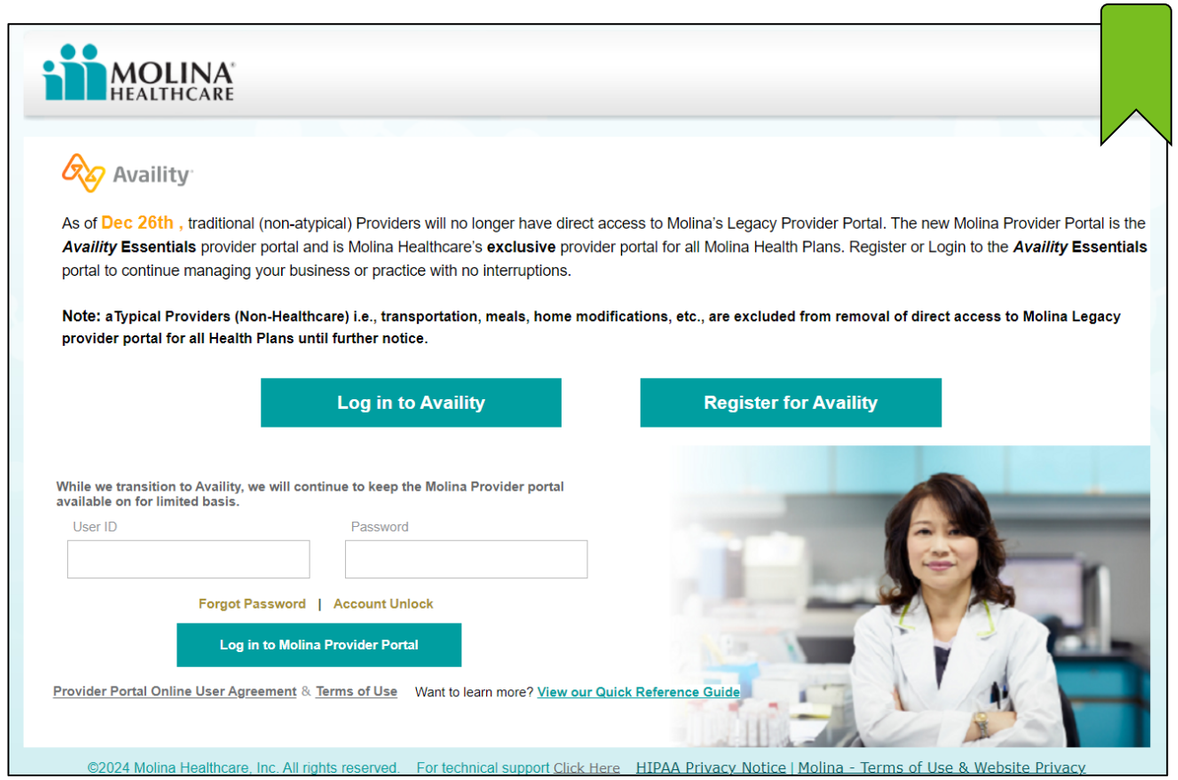
Availity Essentials (Availity) Provider Portal

Core Features

- Verify eligibility and benefits
- Confirm coordination of benefits
- Submit claims (original, correct and void claims)
- Check claim status and ask questions
- Upload medical records, appeals and itemized bills
- Request prior authorization and check the status
- View Electronic Remittance Advice (ERA)

Payer Spaces

- A Payer Space contains links to payer-specific applications, resources, and announcements.
- Molina's Payer Space is accessed via the single sign-on process through Availity Essentials.

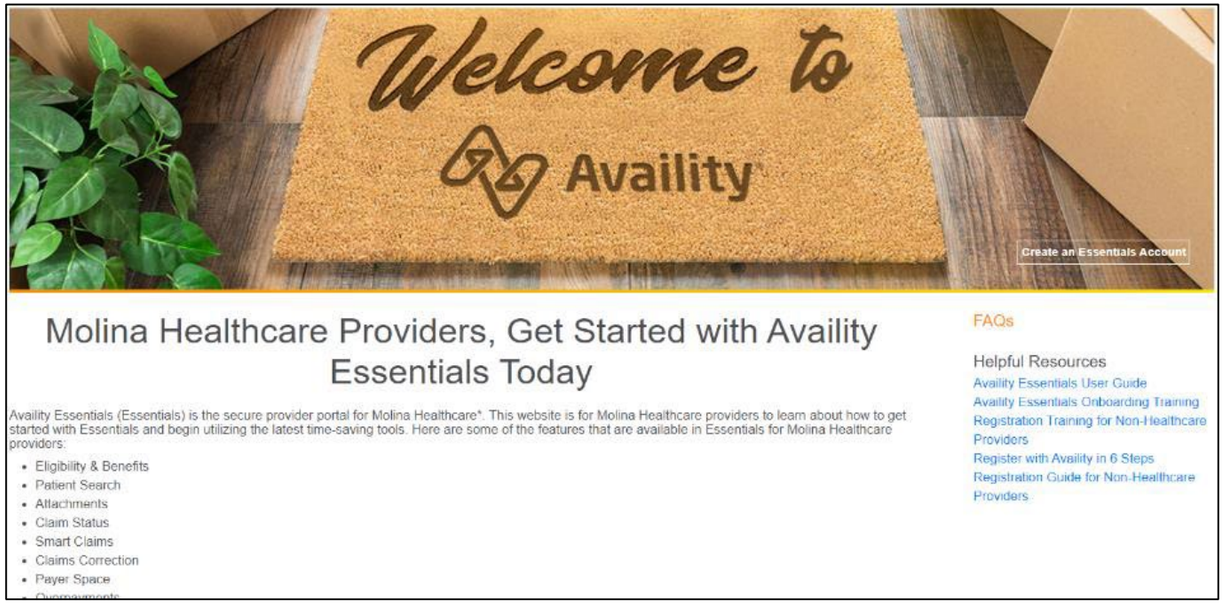


https://www.availity.com/molinahealthcare

Availity Provider Portal

Additional Features and Resources

- Availity User Guides
- Member rosters and redetermination alerts
- Administrative reports
- Healthcare Effectiveness Data and Information Set (HEDIS®) Tip Sheets
- Forms



Check the Availity home page for training opportunities

ECHO Health, Inc.: Electronic Payments and Remittance Advice

Molina contracts with our payment vendor, Change Healthcare, who has partnered with ECHO Health, Inc. (ECHO), for payment delivery and 835 processing.

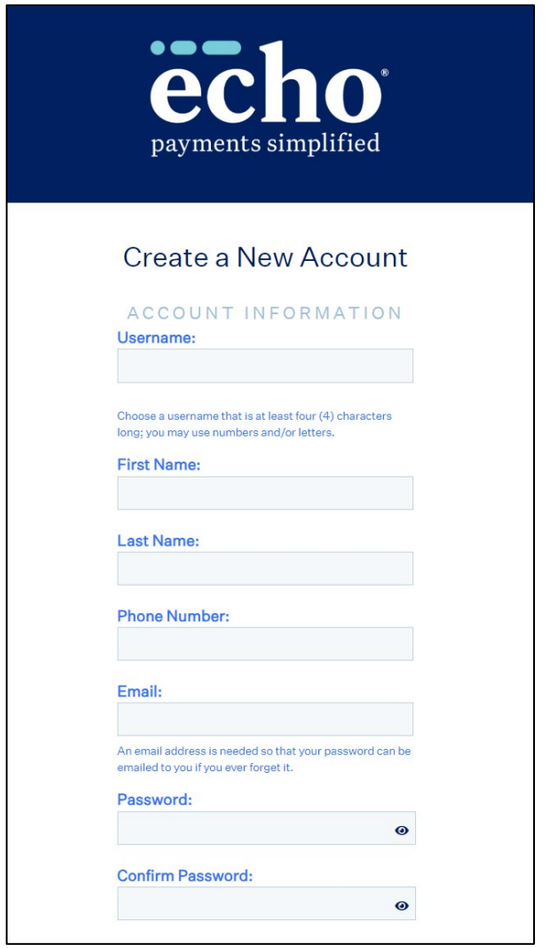
You may receive your payment:

- EFT/ACH,
- Physical check, or
- Virtual Card

You can select a payment preference when you create your account.

Follow the link below to register.

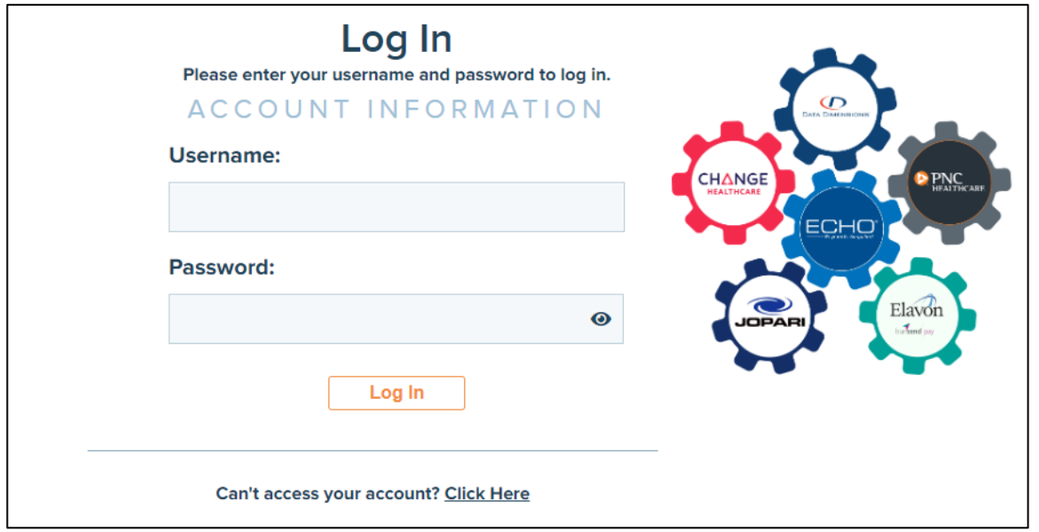
Provider Payments: Register User



ECHO: Electronic Payments and Remittance Advice

Once you have enrolled for electronic payments you will receive the associated ERAs from ECHO with the Molina Payer ID. Please ensure that your Practice Management System is updated to accept the Payer ID referenced below. All generated ERAs will be accessible to download from the ECHO provider portal.

As a reminder, Molina's Payer ID is 46299.



Save the ECHO login page to your favorites once you've created an account.

ECHO Health Provider Login (echohealthinc.com)

ECHO: Electronic Payments and Remittance Advice

Benefits of ECHO

- Administrative rights to sign up/manage your own EFT account Ability to associate new providers within your organization to receive EFT/835s
- View/print/save PDF versions of your Explanation of Payment (EOP) Historical EOP search by various methods (i.e., claim number, member name)
- Ability to route files to your FTP and/or clearinghouse

ECHO Contacts and Links

- Register: Provider Payments: Register User
- Login: ECHO Health Provider Login (echohealthinc.com)
- Customer Service Telephone: **(888) 834-3511**
- Customer Service Email: edi@echohealthinc.com

Credentialing and Provider Updates

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Credentialing and Provider Updates: New Providers

- Credentialing for new providers can take up to 60 days from the date completed documentation is received
- You must have your Medicaid ID before beginning the credentialing process
- New providers require full credentialing using the Molina Healthcare Full Credentialing Packet
- The Attachment C Provider Roster is required for new and existing practitioners
  - We need to know if the provider is solely seeing members in an inpatient setting (hospital, SNF, etc.). If this is the case, then they won't need to be credentialed and will not appear in the directory.
  - We need to collect directory responses for all providers, but it is imperative on mid-levels. If they are then they need full credentialing for us to stay compliant.
  - We need to know their primary care practitioner (PCP) status and desire to see members for member-facing sites and assignments.
- The CAQH application can be submitted in lieu of the Molina Full Credentialing Packet
- If you do not have a CAQH application and are doing the paper application, or if you are a GA-based provider, please fill out the Attestation and Release of Information Form included in the Full Credentialing Packet
- Incomplete applications will be returned

Credentialing and Provider Updates: New Providers

- Molina is only credentialing new mid-level providers who either qualify to be listed as a PCP or wish to appear in the online provider directories. Mid-level PCPs will have members assigned to them.
- Any mid-level PCP or specialist being credentialed who wishes to be in the directory must also their full protocols signed and dated within one year by mid-level and supervising physician.
- Supervising physicians must also be credentialed and par with Molina Healthcare of South Carolina.
- If a mid-level is **not** acting as a PCP and is **not** to appear in the directories, the Attachment C Form is needed. Please ensure the effective date for the group affiliation is completed.
- Once the credentialing process is complete, you will receive a notification letter by email
- The newly credentialed provider will be added to the claims system **30 days following the date of the date of the letter**
- The provider's par date will be **the day after the credentialing date in the letter**

Credentialing and Provider Updates: Provider Load Reminders

Attachment C Provider Roster

- New questions have been added.
- This form is needed whether a provider needs to be credentialed or not
- We need to know if the provider is solely seeing members in an inpatient setting (hospital, SNF, etc.). If this is the case, then they won't need to be credentialed and won’t show in our directory.
- We need to collect directory responses for all providers, but it is imperative on mid-levels. If they are, then they need full credentialing for us to stay compliant.
- We need to know their PCP status and desire to see members for member-facing sites and assignments.

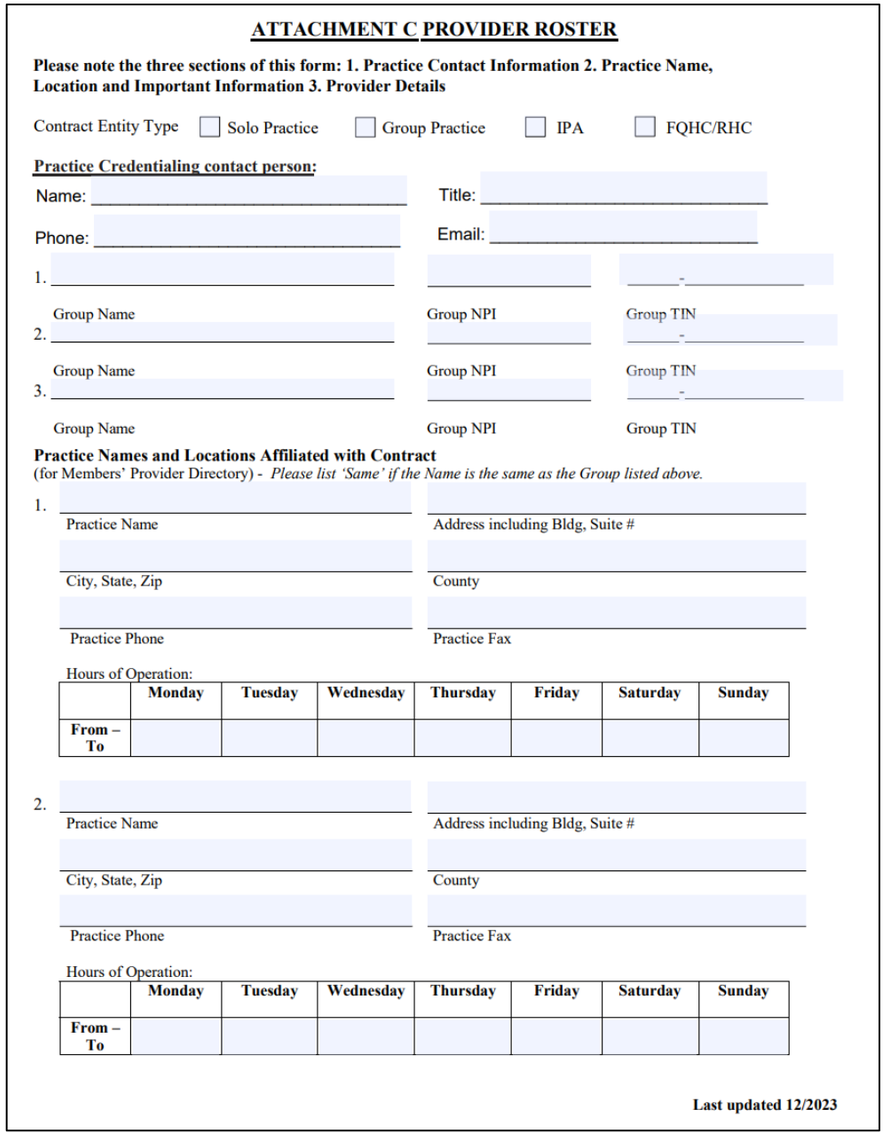
Other Reminders

- If you are affiliating a previously credentialed provider to your practice, it will take 30 days to affiliate the provider to your practice in the claims system. Molina will use the effective date you provide.
- Please notify Molina when a provider terms. We need the provider’s name, NPI, and term date sent to the PSR so we can make sure our directory is accurate.

Credentialing and Provider Updates: Affiliating Practitioners

Attachment C Provider Roster Practice Information

- Pages one-three provide space to list specific practices where the practitioner routinely sees patients
- Locations listed should be practice locations where potential patients can call and make appointments to see the listed practitioner
- Fields include:
  - Practice name
  - Physical address
  - Telephone
  - Fax
  - Hours of operation



ATTACHMENT C PROVIDER ROSTER

Please note the three sections of this form: 1. Practice Contact Information 2. Practice Name, Location and Important Information 3. Provider Details

Contract Entity Type ☐ Solo Practice ☐ Group Practice ☐ IPA ☐ FQHC/RHC

Practice Credentialing contact person:

Name: _____ Title: _____

Phone: _____ Email: _____

1. _____ _____ _____-_____

Group Name Group NPI Group TIN

2. _____ _____ _____-_____

Group Name Group NPI Group TIN

3. _____ _____ _____-_____

Group Name Group NPI Group TIN

Practice Names and Locations Affiliated with Contract
(for Members' Provider Directory) - *Please list 'Same' if the Name is the same as the Group listed above.*

1. _____ _____

Practice Name Address including Bldg, Suite #

_____ _____

City, State, Zip County

_____ _____

Practice Phone Practice Fax

Hours of Operation:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From – To							

2. _____ _____

Practice Name Address including Bldg, Suite #

_____ _____

City, State, Zip County

_____ _____

Practice Phone Practice Fax

Hours of Operation:

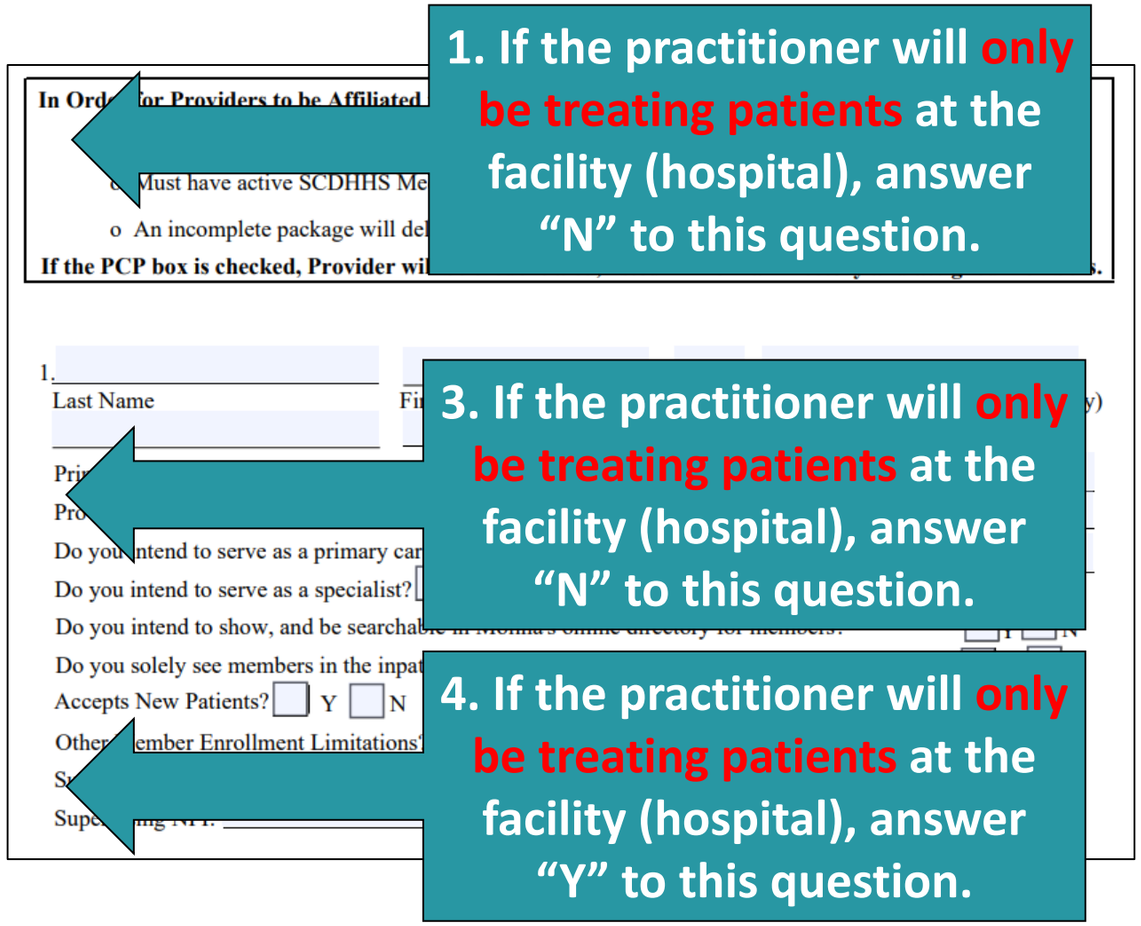
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From – To							

Last updated 12/2023

Credentialing and Provider Updates: Affiliating Practitioners

Attachment C Provider Roster Practitioner Questions

1. Do you intend to serve as a primary care provider?
2. Do you intend to serve as a specialist?
3. Do you intend to show, and be searchable in Molina's online directory for members?
4. Do you solely see members in the inpatient setting, i.e., do NOT take appointments in office?
5. Accepts New Patients?



Provider Network and Credentialing Forms

Updates have been made to some of the Molina Provider Network and Credentialing Forms. Please be sure to use the latest forms to prevent delays and ensure accuracy.

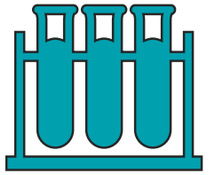
Form Name	Purpose		Where to Send
Credentialing Checklist	Details which documents and forms are required for each provider type		Not applicable
Credentialing Packet	Full credentialing packet; includes guidelines and details which additional documents are required. Required for all new providers who have not been credentialed.		MSC-CREDENTIALING@MolinaHealthcare.com
Practice Demographics Form	Used to provide practice demographics and ensure provider directory accuracy		MHSCPODValidation@MolinaHealthcare.com
Provider Change Form	Used to keep the provider network information current; all notifications are needed within 30 days of the change. Examples of use include practice name or location change, new phone number, a change in office hours.		SCNetworkAdministration@MolinaHealthcare.com
Contract Request Form	Used to request specific contracts and initiate participation with the applicable network		SCProviderContract@MolinaHealthcare.com
Facility HDO Form	Facilities wishing to provide information for all location types: • Atypical Providers • Durable Medical Equipment Suppliers	• Indian Health Clinics • Laboratories • Radiology • Transportation Services	MSC-CREDENTIALING@MolinaHealthcare.com
Attachment C Provider Roster	Used to provide detailed practice information including locations, practitioners, PCP designation, Medicaid and Medicare IDs, etc.		SCNetworkAdministration@MolinaHealthcare.com

Credentialing and Contracting Quick Links

- SCDHHS Provider Enrollment Information
- Molina Frequently Used Forms
- CAQH Provider Data Portal landing page (formerly CAQH ProView)
- Molina Credentialing email address: MSC-Credentialing@MolinaHealthcare.com
- Molina Provider Network email address: SCNetworkAdministration@MolinaHealthcare.com

Refer Members to Network Participating Providers

- **Use the Online Provider Directory**
  - Search by category
  - Report inaccuracies
  - Find other network participating providers to refer members



- Molina is analyzing data on providers who are referring members to non-par labs
  - Moving forward we will be monitoring physicians who are sending work to non-participating providers
  - We will make outreach to these practitioners to better understand why and work on providing education that will help direct services to in-network providers
  - Quest Diagnostics® is Molina's preferred lab; they are a low cost, high quality, laboratory, that provides Molina with lab results that factor into quality measures and calculations

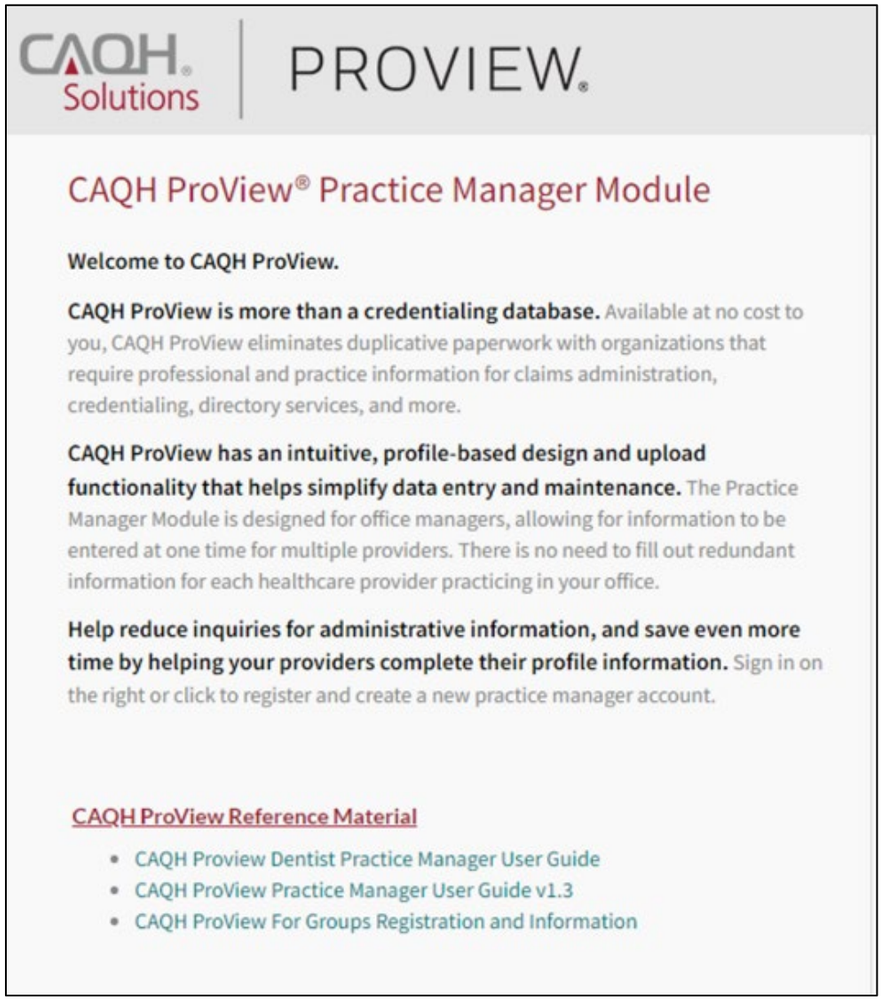
Council for Affordable Quality Healthcare® (CAQH)

Reminders

- Audits are run monthly to verify CAQH information vs. what is in our database
- Conflicting info will lead to a term in Molina system

Verify

- Attestation is up to date
- Molina is granted access
- Primary location(s) and group info
- Licensure, certifications, and insurance not expiring within 60 days



Prior Authorization and Healthcare Services (HCS)

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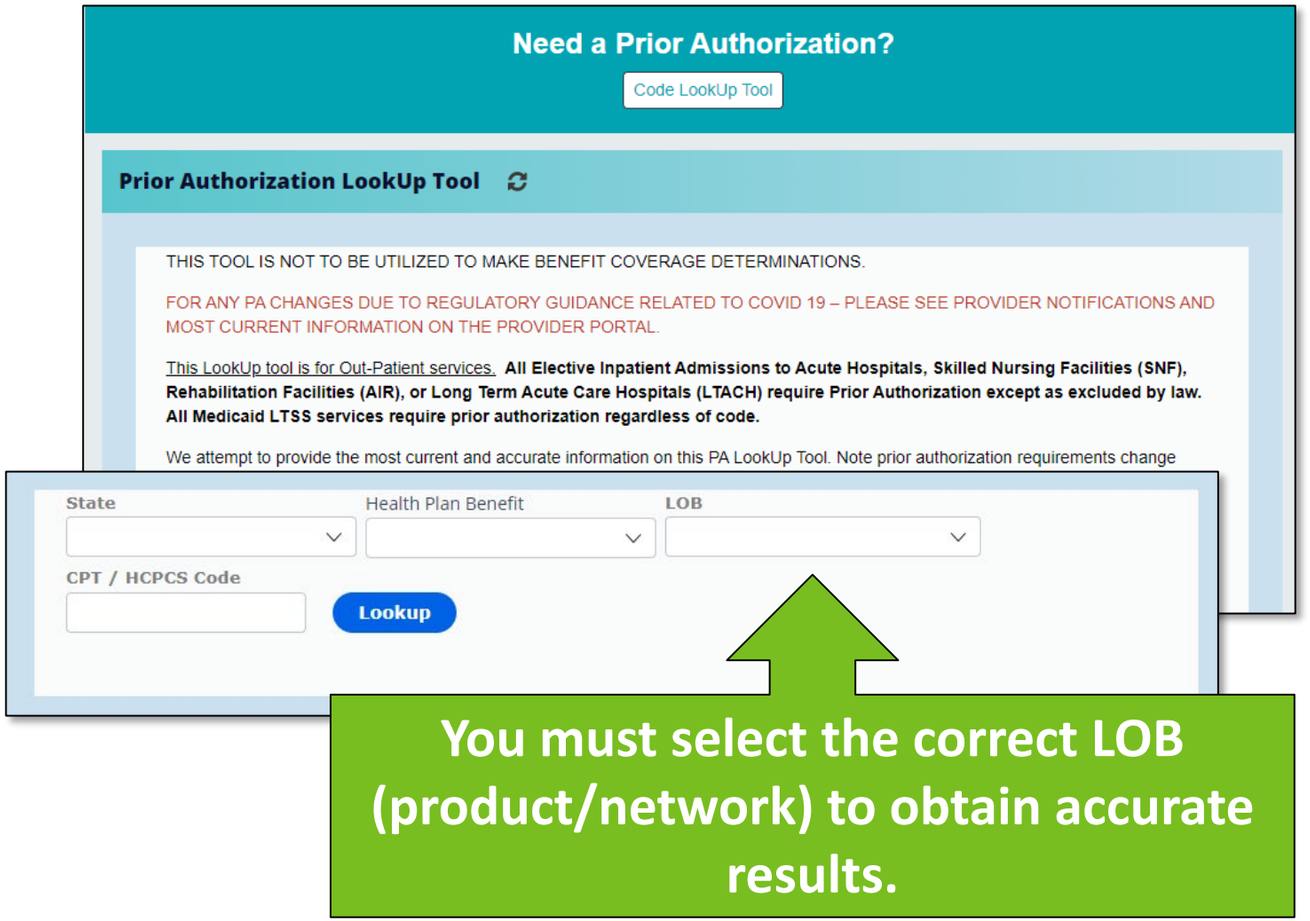
Prior Authorization (PA) LookUp Tool

PA LookUp

- Tools is a located on the Molina Healthcare Provider landing page
- Scroll down and select South Carolina from the State box
- Select the applicable product/network
- Enter CPT/HCPC code



Prior Authorizations are required for all non-par offices/providers/facilities visits, surgical procedures, labs, diagnostic studies, and inpatient stays except for ER services.

HCS and Prior Authorizations

HCS decision making is based only on appropriateness of care and service and existence of coverage. The provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Prior authorizations may be submitted by fax to **(866) 423-3889** or through Availity. Availity can be used to check the status of all prior authorization requests, regardless of how the request was submitted.

Common reasons for delays or denial of the request:

- Insufficient or missing clinical information to provide for making the decision
- Lack of or missing progress notes or illegible documentation
- Request for an urgent review when there is no medical urgency

Prior Authorization Approval

Standard Prior Authorization

- Authorization requests for elective services and procedures
- Decisions are made and notification is provided within **14 calendar days**
- For approved services, the provider will receive an authorization number, by phone or fax.
- For denied services, the provider will receive a faxed letter. The member will receive a letter by mail. The letter will explain the reason for the denial and additional information regarding the grievance and appeals process.

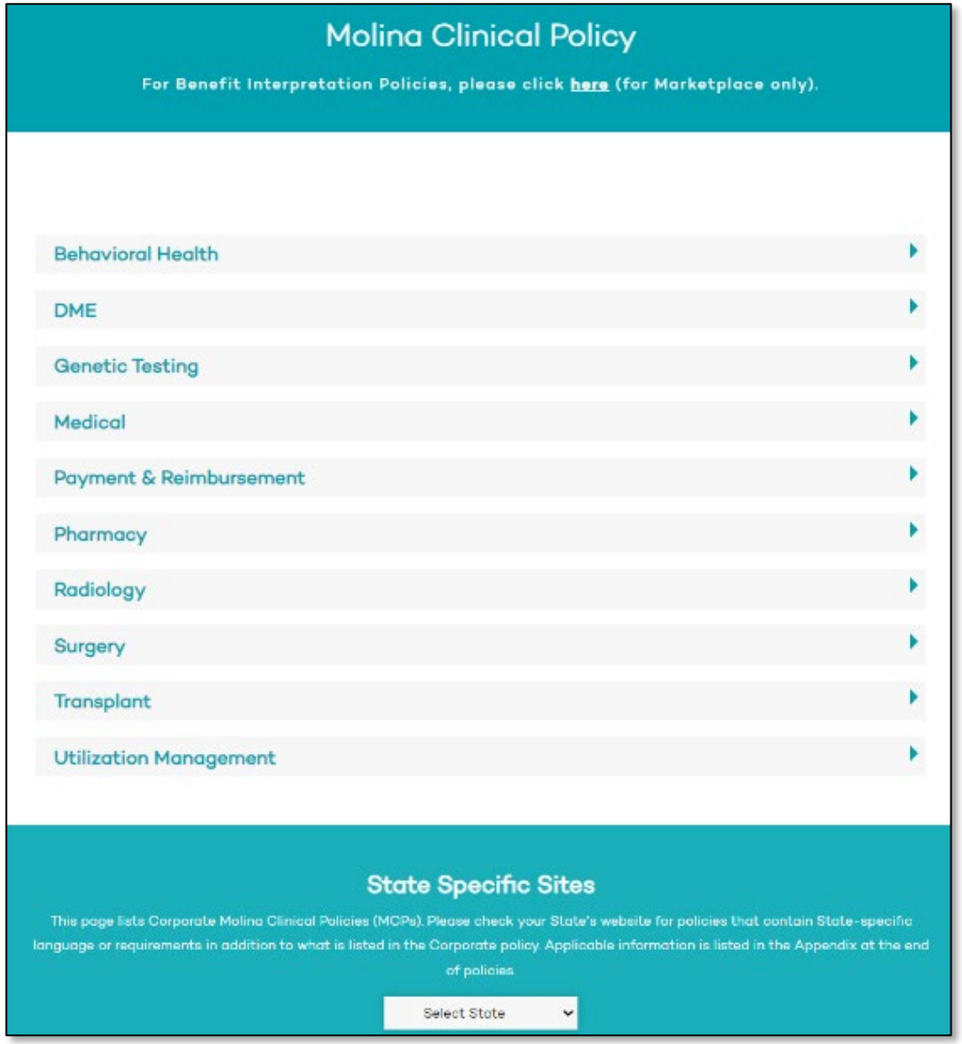
Expedited Prior Authorizations

- Decisions where the member's life or health may be jeopardized; or could jeopardize the member's ability to regain maximum function.
- Providers must provide supporting documentation to justify an expedited authorization request. Without sufficient justification the authorization request may be downgraded and processed as a standard request.
- Decisions are made and notification is provided within **seventy-two hours or three calendar days** from receipt of the request
- When services are approved, the provider will receive an authorization number, by phone or fax.
- Denied services, the provider will receive a faxed letter. The member will receive a letter by mail. The letter will explain the reason for the denial and additional information regarding the grievance and appeals process.

Prior Authorizations: Clinical Policies

Molina Clinical Policy

- Lists Corporate Molina Clinical Policies (MCPs)
- Includes a link to view state specific policies
- Set of guidelines for coverage decisions and necessity determinations.



Prior Authorizations: When Other Insurance as Primary

Members with Other Health Insurance as Primary

If the primary will authorize or cover the service (i.e., payment is made) then authorization is **not required by Molina**.

If the Service is *Non-covered* by the Primary Carrier:

- Initiate a PA and send notes from the primary
- Pull the official stance on the service from their website
- If you have already performed the service, you can submit the EOB showing it is not covered or exhausted, however, if it doesn't meet medical necessity then we will deny the PA and claim.

Prior Authorizations: ProgenyHealth

Progeny for NICU Babies (Medicaid)

We have an ongoing partnership with ProgenyHealth, a company that specializes in neonatal care management services. This is an exciting opportunity. ProgenyHealth's care management program will enhance services to our members and support our mission to make a lasting difference in our members' lives by improving their health and well-being.

ProgenyHealth's Neonatologists, Pediatricians, and Neonatal Nurse Care Managers will work closely with Molina members, as well as attending physicians and nurses, to promote healthy outcomes for Molina premature and medically complex newborns.

The benefit of this partnership to you:

- The support of a team that understands the complexity and stress of managing infants in the NICU and will work with you to achieve the best possible outcomes
- A collaborative and proactive approach to care management that supports timely and safe discharge to home
- A company that believes in sharing best practices and works with NICUs nationwide to improve the health outcomes of our next-generation

The fax number for ProgenyHealth is **(888) 250-8468**.

Prior Authorizations: MCG Cite for Guideline Transparency

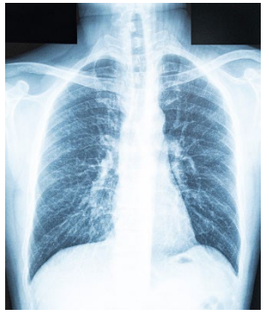
Molina has partnered with MCG Health to implement Cite for Guideline Transparency. Providers can access this feature through Availity. With MCG Cite for Guideline Transparency, Molina can share clinical indications with Providers. The tool operates as a secure extension of Molina's existing MCG investment and helps meet regulations around transparency for delivery of care:

- Transparency—Delivers medical determination transparency.
- Access—Clinical evidence that payers use to support member care decisions.
- Security—Ensures easy and flexible access via secure web access.

MCG Cite for Guideline Transparency does not affect the process for notifying Molina of admissions or for seeking Prior Authorization approval. To learn more about MCG or Cite for Guideline Transparency, visit MCG's website or call (888) 464-4746.

Prior Authorizations: MCG Cite AutoAuth

Molina has also partnered with MCG Health, to extend our Cite AutoAuth self-service method for all lines of business to submit advanced imaging PA requests.



- Through a customized rules engine, Cite AutoAuth compares Molina's specific criteria to the clinical information and attached guideline content to the procedure to determine the potential for auto authorization.
- Self-services available via the Cite AutoAuth tool include but are not limited to MRIs, CTs, and PET scans
  - Accessed via Availity and is available 24 hours per day, seven days per week.
  - Used as a primary submission route although the existing fax, phone, and email methods of submission are still available.
  - Quicker and more efficient processing of your authorization request and the status of the authorization will be available immediately upon completion of your submission.
  - Attaching the relevant care guideline content to each PA request and sending it directly to Molina, providers will receive an expedited, often immediate, response.

Prior Authorizations: Peer to Peer

Peer to Peer:

- You have **five business days** from a denial notification to schedule a Peer to Peer (P2P)
- Requests to discuss any medical necessity determinations with Medical Director can be made by:
  - Telephone: **(855) 237-6178**
  - Fax: **(866) 423-3889**
  - Email: mhscpriorauth@MolinaHealthcare.com
- When requesting a peer-to-peer discussion, please be prepared with the following information:
  - Member name and Molina ID number
  - Authorization number
  - Requesting provider name, contact number, the best times to call and provide more than one option for the Molina Medical Director to contact the provider (best times are Monday through Friday, between 10 a.m. to 4 p.m., EST)
  - Updated clinicals if available
- An appeal may still be required if applicable
- You have up to **60 days** from the date of denial to file an appeal on behalf of the member.

HCS: Care Management

Molina offers programs to help our members and their families manage a diagnosed health condition with Health Education, Disease Management, Care Management, and Complex Case Management.

You as a provider also help us identify members who may benefit from these programs. Members can request to be enrolled or disenrolled in these programs.

Our programs include:

- Asthma management
- Diabetes management
- High blood pressure management
- Cardiovascular Disease (CVD) management/Congestive Heart Disease
- Chronic Obstructive Pulmonary Disease (COPD) management
- Depression management

For more information about our programs, please call Provider Services at (855) 237-6178 (TTY: 711).

Payment Integrity

MOLINA® HEALTHCARE

You Matter to Molina

Payment Integrity: High Dollar Claims

- Inpatient charges over $100,000
  - Itemized bills are required
  - Can be attached to the initial claim via Availity or paper
- If we do not receive the itemized bill, we will either pay the base rate or deny charges altogether.
- For more details, please refer to PI Payment Policy 01 Hospital Routine Supplies Services Reimbursement.

You may receive medical records requests from Molina or a third party on our behalf to conduct payment integrity activities. Please respond to these requests to ensure prompt, accurate adjudication.

Payment Integrity: Pre-payment Audits and Optum

The purpose of conducting pre-pay reviews is to ensure that services billed are consistent with medical record documentation

What is the remark code?

Remit Remark Code M127

What is the remit message?

"Optum requesting Medical Records on Molina's behalf. The allowed timeframe for Medical Record submission and any disputes is based on timely filing requirements. Please direct questions regarding this Medical Record request to Optum at (877) 244-0403."

How do I submit medical records? What should I include?

If you receive a request for medical records from Optum, please follow the instructions in the letter. The letter will provide details of how and where to submit your medical records and what to include with your submission. Submission options vary, depending on market requirements. A URL Upload and fax option are available for all markets.

Review the Pre-Pay Audit Frequently Asked Questions and PI Payment Policy 29 Optum Pause and Pay resources for more information.

Payment Integrity: Sepsis Diagnosis

- Molina performs a pre-payment and post-payment review of all Sepsis-related claims across all product lines.
- Molina uses Sepsis 3 Criteria and the Sequential Organ Failure Assessment (SOFA) scoring.
- If the clinical documentation reviewed ***does not*** support Sepsis definitions, the Sepsis diagnosis will be removed, and payment will be adjusted accordingly.
- Providers will have standard reconsideration timelines via the Claims Reconsideration Process for MHSC to review the additional documentation from providers, please ensure you clearly indicate you are appealing the Sepsis decision.

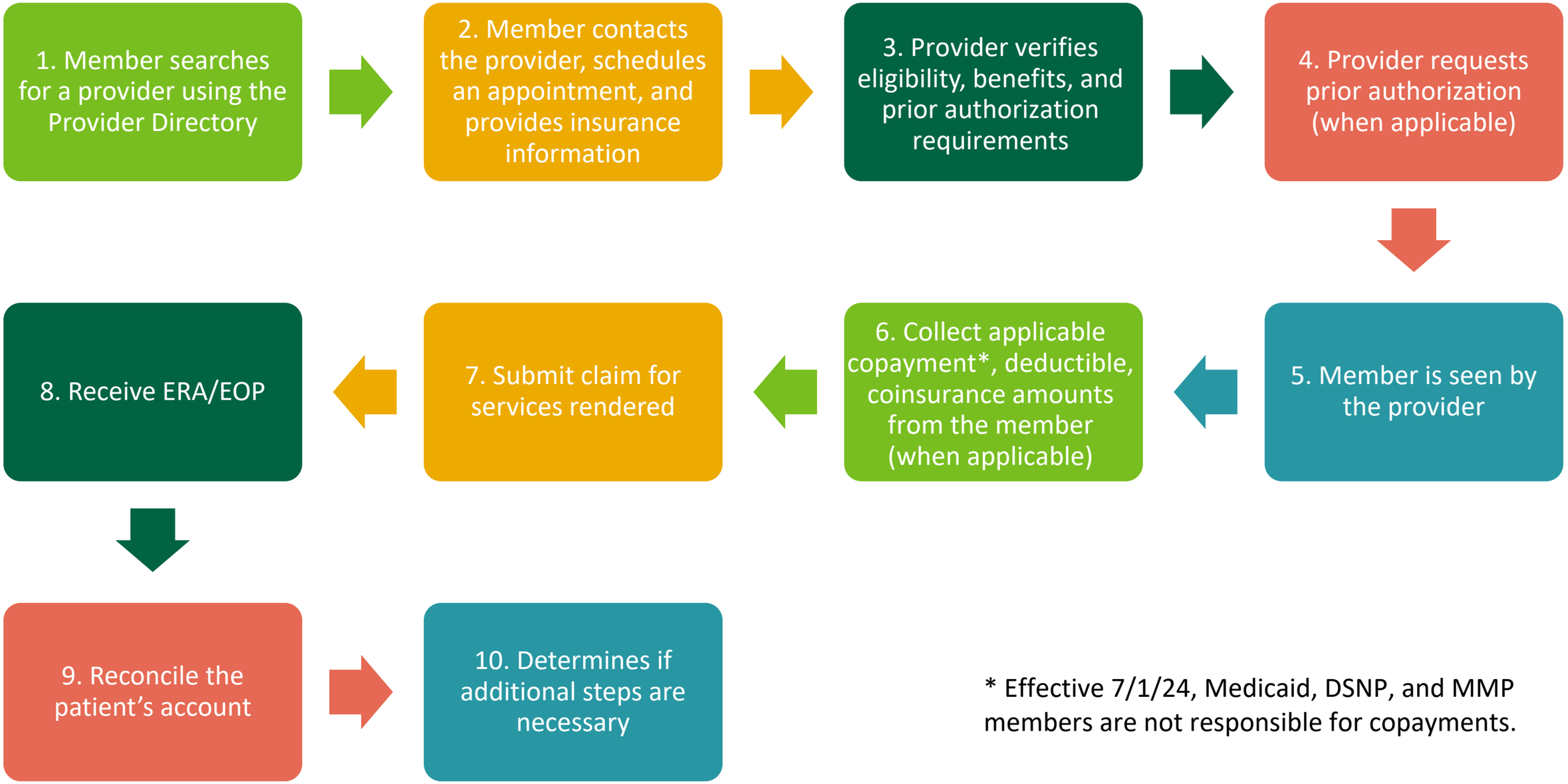
Review PI Payment Policy 26 Sepsis for additional information

Cycle of Care

MOLINA® HEALTHCARE

You Matter to Molina

Cycle of Care



* Effective 7/1/24, Medicaid, DSNP, and MMP members are not responsible for copayments.

Step 3-4: Eligibility, Benefits, and Prior Authorization

Eligibility

- Check Electronically using a Clearinghouse
- Availity
- Use the SCDHHS Healthy Connections Portal to confirm Medicaid eligibility
- Call Molina Provider Services
- Review Applicable Molina Clinical Policies

Benefits

- Check Electronically using a Clearinghouse
- Availity
- Call Molina Provider Services (or applicable benefit vendor)
- Comprehensive Drug List and Site of Care Drug List (use to verify approved drugs)

Prior Authorization

- Prior Authorization Code LookUp Tool
- Availity
- Call Health Care Services (or applicable authorization vendor)

Step 7: Submit Claim

Submit Electronically using a Clearinghouse

- EDI or electronic claims are processed faster than paper claims. Providers may use any clearinghouse. Note that fees may apply.
- Use payer ID: 46299

Submit Online with Availity

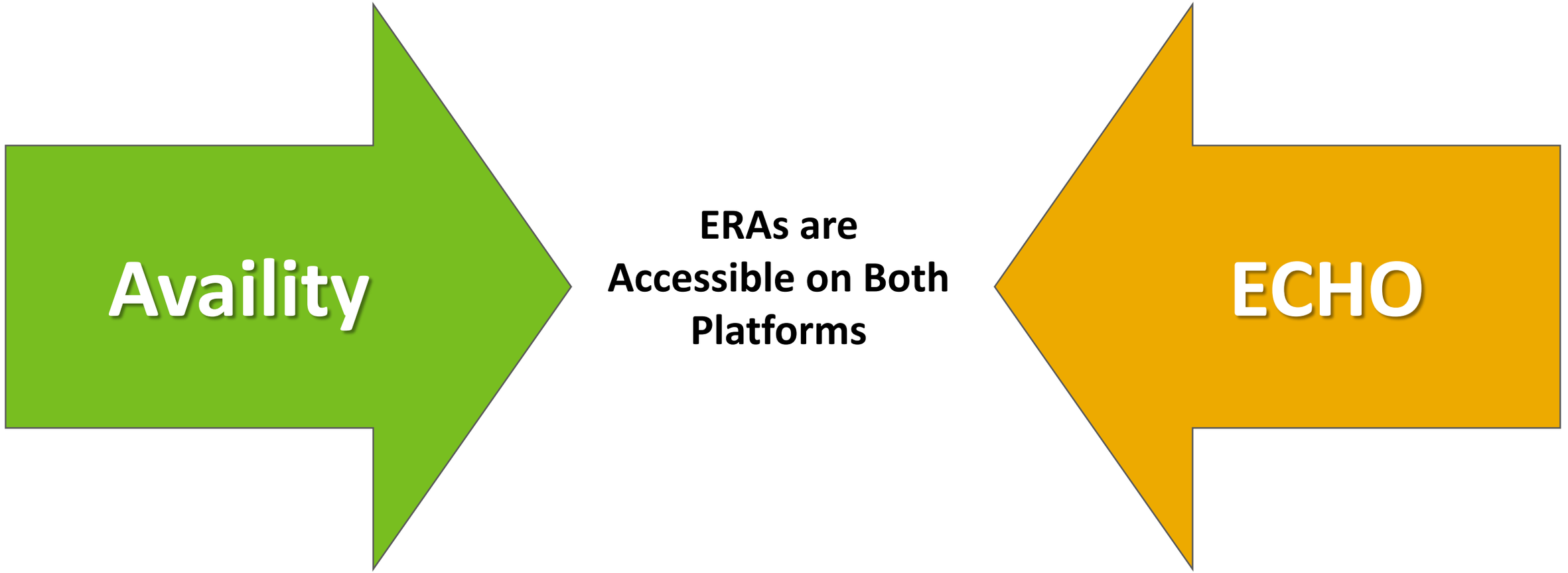
- Submit original, corrected, or void claims
- Create and manage claim templates
- Add attachments to claims
- Save incomplete/unsubmitted claims

Fast and Free!

Paper Claims

Mail to Molina using the address on the back of the member's card

Step 9: Reconcile Patient's Account



Step 10: Determine if Additional Steps are Necessary

1. File a Corrected Claim

- Submit a corrected claim when appropriate
- Include the original claim number in the appropriate box or loop segment

2. Submit Medical Records

- Records may be requested from Molina or one of our business partners
- Respond to record requests as soon as possible and send them to the appropriate requestor

3. Contact Molina

- Inform Molina when you disagree with the adjudication of a claim
- Ask specific questions using Availity
- Call Provider Services

4. File a Formal Appeal

- Upload through Availity
- Include an explanation of what is being appealed (a specific denial, payment discrepancy, etc.)
- Attach relevant medical records

5. Contact Your Provider Relations Representative

Email your representative and include details:

- Member ID
- Member name
- Claim number
- Issue
- Steps taken
- Expected outcome

Instructions for submitting formal appeals can be found in the corresponding product manual.

Claim Submission Timelines

	Medicaid	Medicare	MMP (Dual)	Marketplace
Timely Filing Limit	**12 months/365 days** after the discharge for inpatient services or the date of service for outpatient services	**365 calendar days** after the discharge for inpatient services or the date of service for outpatient services	**365 calendar days** after the discharge for inpatient services or the date of service for outpatient services	**365 days** from the date of service
Corrected Claims	**365 calendar days** from the date of service	**365 calendar days** from the date of service or most recent adjudicated date of the claim	**365 calendar days** from the date of service	**365 days** from the date of service
Third Party Liability (TPL)/Coordination of Benefits (COB)	**12 months/365 days** from date of service after final determination by the primary payer	**365 calendar days** after final determination by the primary payer	**365 calendar days** after final determination by the primary payer	**120 calendar days** after final determination by the primary payer
Claim Disputes/ Reconsiderations	Requests must be made within **90 calendar days** of Molina's original remittance advice date	Requests must be made within **120 calendar days** of Molina's original remittance advice date or longer as stated in the Provider Agreement.	Requests must be made within **120 calendar days** of Molina's original remittance advice date or longer as stated in the Provider Agreement.	Requests must be made within **90 days** of Molina's original remittance advice date.

Refer to the respective Provider Manual for additional information and details regarding claim submission and reconsiderations.

Quality Improvement

MOLINA® HEALTHCARE

You Matter to Molina

Quality Improvement Initiatives and Programs

Healthcare Effectiveness and Data Information Set (HEDIS®)

- A widely used performance improvement tool used to measure performance on important dimensions of care and service across six domains of care:
  - Effectiveness of care
  - Accessibility of care
  - Experience of care
  - Utilization and risk adjusted utilization
  - Heah plan descriptive information
  - Measures reported using electronic clinical data systems
- Measures address a range of health issues including:
  - Medication adherence
  - Preventive screenings
  - Immunizations
  - Managing chronic conditions (e.g., diabetes, asthma, high blood pressure)

HEDIS Data Collection

- Claims
- Medical records
- Supplemental data source
  - Molina offers a variety of data exchange methods, the one most often used is the Supplemental Data Feed
  - Information such as diagnosis codes, labs and CPT codes are collected directly from your EMR system
  - The data feed captures information that may not be billed on a claim, acting as a data safety net

Information captured from a Supplemental Data Feed can be used to increase HEDIS compliance and close gaps in care, thereby reducing (and often eliminating) the need for medical records.

Quality Improvement Initiatives and Programs

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

- CAHPS is a tool used by Molina to summarize member satisfaction with providers, health care, and services they receive.
- Examines specific measures, including:
  - Getting Needed Care,
  - Getting Care Quickly,
  - How Well Doctors Communicate,
  - Coordination of Care,
  - Customer Service,
  - Rating of Health Care and
  - Getting Needed Prescription Drugs (for Medicare)
- The survey is administered annually in the to randomly selected members by a National Committee for Quality Assurance (NCQA)-certified vendor.
- Results form the basis for several of Molina's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

Measure	2022	2023	Goal
Getting Care Quickly	86.9%	87.9%	88.5%
Getting Needed Care	NA	83.3%	85.6%
Coordination of Care	NA	83.9%	86.5%
Rating of All Health Care	76.2%	73.2%	70.7%
Rating of Personal Doctor	80.9%	80.4%	77.8%
Rating of Specialist Seen Most Often	NA	NA	73.6%
Rating of Health Plan	72.1%	72.1%	73.8%

Quality Improvement Initiatives and Programs

Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey)

- The QHP Survey is a survey that measures member experience with QHPs offered in the Marketplace.
- An independent, Health and Human Services (HHS)-approved group surveys Molina members each year.
- CMS rates qualified health plans (QHPs) offered through the Exchanges using the Quality Rating System (QRS), which is based on third-party validated clinical measure data and QHP Enrollee Survey response data.
- CMS calculates QRS ratings annually using a 5-star scale.
- QHP issuers contract with HHS-approved survey vendors that independently conduct the QHP Enrollee Survey each year.
- QRS ratings and QHP Enrollee Survey results may change from one year to the next. For more information, please see CMS' Health Insurance Marketplace℠ Quality Initiatives website at CMS.gov

Measure	2022	2023	Goal
Access to Care	73.0%	73.15	74.0%
Access to Information	53.8%	55.2%	54.7%
Annual Flu Vaccine (Adults 18-64)	37.1%	36.9%	57.3%
Coordination of Care	81.5%	83.2%	85.3%
Customer Service	71.0%	71.1%	73.4%
Medical Assistances with Smoking and Tobacco Use Cessation	59.8%	61.8%	60.7%
Rating of Health Plan	76.5%	75.8%	73.9%
Rating of Personal Doctor	87.8%	89.8%	89.1%
Rating of Specialist Seen Most Often	85.5%	81.7%	86.9%

Quality Improvement Initiatives and Programs

Facilitating & encouraging preventive care for healthy members and those with chronic conditions

- Pregnancy Rewards for new and expecting moms
- Prenatal Care

Mothers-to-Be

- Targeted provider incentives
- Focused diabetes, hypertension and asthma programs
- Comprehensive support and educational material

Provider Programs

- HEDIS® and CAHPS® education and awareness
- Post-appointment member survey for feedback on member satisfaction with provider services

(CAHPS®) Survey

Medicaid Incentives and Added Benefits

Members receive incentives for specific care:

- Well visits
- Immunizations
- Prenatal and postnatal care
- Breast cancer screenings
- Cervical cancer screenings
- Chlamydia screenings
- Diabetes care
- And more

Member Incentives include:

- Gift cards
- Free bike and helmet

Added benefits and programs:

- Mom's Meals
- Free breast pumps
- Fee car seats

Incentives are paid to network participating providers for specific care:

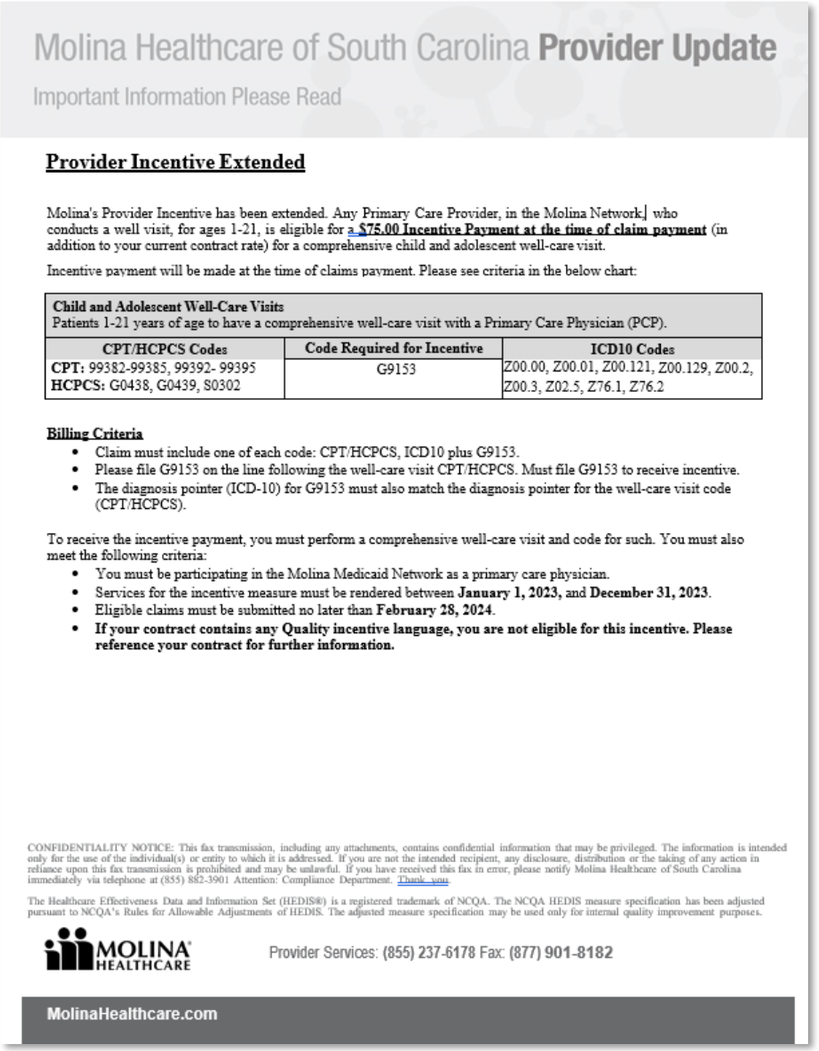
- Well visits (ages 1-21 years) (PCPs)
- HPV vaccines (ages 9-13 years)
- Flu vaccines (ages 6 months-2 years)

- Incentives vary and are awarded at the time eligible claims are adjudicated
- Claims must include specific data to be eligible

Visit the Medicaid Member Rewards page or the Medicaid Member Value Add Benefits page for more information

Provider Incentive Program: Well Visits (1/1/2024-4/30/2024)

- Pays **$75.00** for Well Visits for Members 1-21 Years of Age
- Incentive Paid at Claim Adjudication
- Effective for Dates of Service **1/1/2024 – 4/30/2024**
- Claim Must Include:
  - Preventative Code
  - Encounter Diagnosis Code
  - **G9153** Incentive Code
- Claims must be submitted by **2/28/2025**
  - Onsite and Telehealth claims are eligible for this incentive
- Payable when Medicaid is primary



Molina Healthcare of South Carolina **Provider Update**

Important Information Please Read

Provider Incentive Extended

Molina's Provider Incentive has been extended. Any Primary Care Provider, in the Molina Network, who conducts a well visit, for ages 1-21, is eligible for a **$75.00 Incentive Payment at the time of claim payment** (in addition to your current contract rate) for a comprehensive child and adolescent well-care visit.

Incentive payment will be made at the time of claims payment. Please see criteria in the below chart:

Child and Adolescent Well-Care Visits Patients 1-21 years of age to have a comprehensive well-care visit with a Primary Care Physician (PCP).		
CPT/HCPCS Codes	**Code Required for Incentive**	**ICD10 Codes**
CPT: 99382-99385, 99392- 99395 **HCPCS:** G0438, G0439, S0302	G9153	Z00.00, Z00.01, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2

Billing Criteria

- Claim must include one of each code: CPT/HCPCS, ICD10 plus G9153.
- Please file G9153 on the line following the well-care visit CPT/HCPCS. Must file G9153 to receive incentive.
- The diagnosis pointer (ICD-10) for G9153 must also match the diagnosis pointer for the well-care visit code (CPT/HCPCS).

To receive the incentive payment, you must perform a comprehensive well-care visit and code for such. You must also meet the following criteria:

- You must be participating in the Molina Medicaid Network as a primary care physician.
- Services for the incentive measure must be rendered between **January 1, 2023,** and **December 31, 2023**.
- Eligible claims must be submitted no later than **February 28, 2024**.
- **If your contract contains any Quality incentive language, you are not eligible for this incentive. Please reference your contract for further information.**

MOLINA HEALTHCARE

Provider Services: (855) 237-6178 Fax: (877) 901-8182

MolinaHealthcare.com

Provider Incentive Program: Well Visits (5/1/2024-12/31/2024)

- Pays **$75.00** for Well Visits for Members 1-21 Years of Age
- Incentive Paid at Claim Adjudication
- Effective for Dates of Service **5/1/2024 – 12/31/2024**
- Claim Must Include:
  - Preventative Code
  - Encounter Diagnosis Code
  - **G9153** Incentive Code
  - **Applicable BMI percentile diagnosis code for members ages 3 years and up**
- Claims must be submitted by **2/28/2025**
  - Onsite and Telehealth claims are eligible for this incentive
- Payable when Medicaid is primary

Child and Adolescent Well Care Visits Patients 1-21 years of age to have a comprehensive well-care visit with a primary care physician (PCP).			
CPT/HCPCS for Well Child Visit	**Well Visit Incentive Code**	**ICD-10 Codes for Well Visit Encounter**	***BMI Percentile ICD-10**
CPT: 99382-99385, 99392-99395 HCPCS: G0438, G0439, S0302	G9153	Z00.00, Z00.01, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2	Z68.51, Z68.52, Z68.53, Z68.54

Well Visits

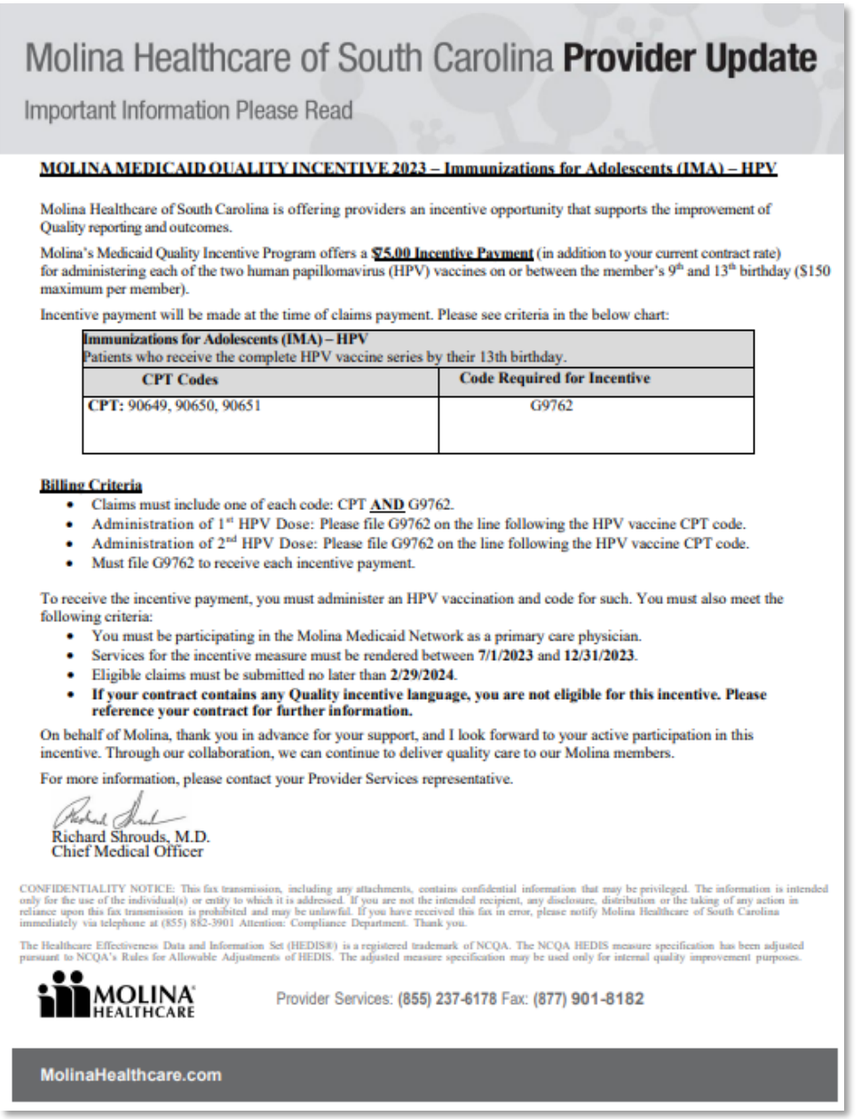
- Molina will reimburse any PCP provider for completing a well visit. Member does not have to be assigned to PCP for well visit reimbursement.
- Convert sick visit to well visit with use of the appropriate modifier: 25 indicating a significant, separately identifiable E/M service was provided by the same physician on the same day as the preventive medicine service.
- Free Sports Physicals – Offer a well child check in lieu of a Sports Physicals. Sports Physicals are not a covered service for Medicaid. Diagnoses Z02.5 and Z71.82 will meet Counseling for Physical Activity – WCC sub measure only

The well visit benefit for ages 3-21 are **no longer based on birthdate, well visit anniversary date, rolling year or 365+1 days from prior year well visit**.

Well visits may be performed at **anytime** during a calendar year.

Provider Incentive Program: HPV Vaccine

- Pays **$75.00** for Administering HPV Vaccines to Members 9-13 Years of Age
- Incentive Paid at Claim Adjudication
- Administering Each of the 2 HPV Vaccines
- Effective for Dates of Service **1/1/2024 – 12/31/2024**
- Claim Must Include:
  - Preventative Code
  - Encounter Diagnosis Code
  - **G9762** Incentive Code
- Claims must be submitted by **2/28/2025**
- Payable when Medicaid is primary



Molina Healthcare of South Carolina **Provider Update**

Important Information Please Read

MOLINA MEDICAID QUALITY INCENTIVE 2023 – Immunizations for Adolescents (IMA) – HPV

Molina Healthcare of South Carolina is offering providers an incentive opportunity that supports the improvement of Quality reporting and outcomes.

Molina's Medicaid Quality Incentive Program offers a **$75.00 Incentive Payment** (in addition to your current contract rate) for administering each of the two human papillomavirus (HPV) vaccines on or between the member's 9th and 13th birthday ($150 maximum per member).

Incentive payment will be made at the time of claims payment. Please see criteria in the below chart:

Immunizations for Adolescents (IMA) – HPV Patients who receive the complete HPV vaccine series by their 13th birthday.	
CPT Codes	**Code Required for Incentive**
CPT: 90649, 90650, 90651	G9762

Billing Criteria

- Claims must include one of each code: CPT **AND** G9762.
- Administration of 1st HPV Dose: Please file G9762 on the line following the HPV vaccine CPT code.
- Administration of 2nd HPV Dose: Please file G9762 on the line following the HPV vaccine CPT code.
- Must file G9762 to receive each incentive payment.

To receive the incentive payment, you must administer an HPV vaccination and code for such. You must also meet the following criteria:

- You must be participating in the Molina Medicaid Network as a primary care physician.
- Services for the incentive measure must be rendered between **7/1/2023** and **12/31/2023**.
- Eligible claims must be submitted no later than **2/29/2024**.
- **If your contract contains any Quality incentive language, you are not eligible for this incentive. Please reference your contract for further information.**

On behalf of Molina, thank you in advance for your support, and I look forward to your active participation in this incentive. Through our collaboration, we can continue to deliver quality care to our Molina members.

For more information, please contact your Provider Services representative.

Richard Shrouds, M.D.
Chief Medical Officer

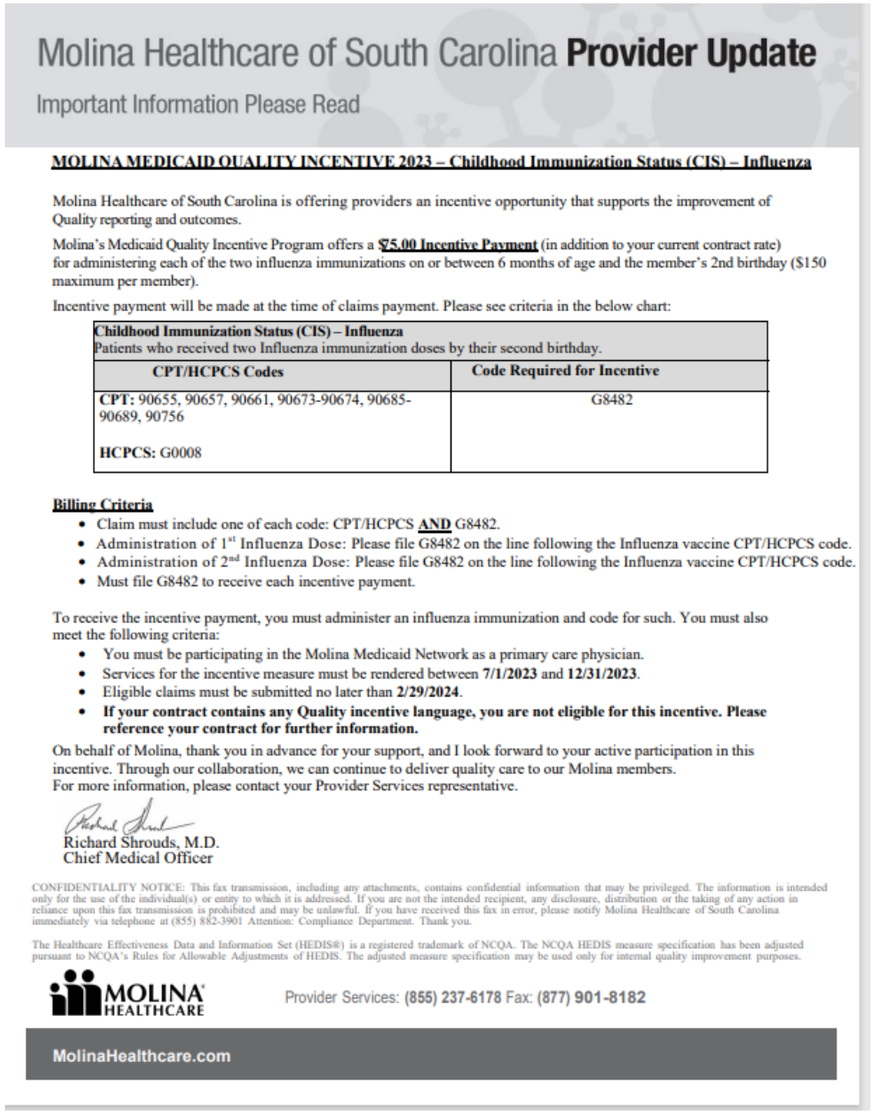
MOLINA HEALTHCARE

Provider Services: (855) 237-6178 Fax: (877) 901-8182

MolinaHealthcare.com

Provider Incentive Program: Flu Vaccine

- Pays **$75.00** for Administering Flu Vaccines to Members 6 months-2 Years of Age
- Incentive Paid at Claim Adjudication
- Effective for Dates of Service **1/1/2024 – 12/31/2024**
- Claim Must Include:
  - Influenza CPT (1st or 2nd)
  - **G8482** Incentive Code
- Claims must be submitted by **2/28/2025**
- Payable when Medicaid is primary



Molina Healthcare of South Carolina **Provider Update**

Important Information Please Read

MOLINA MEDICAID QUALITY INCENTIVE 2023 – Childhood Immunization Status (CIS) – Influenza

Molina Healthcare of South Carolina is offering providers an incentive opportunity that supports the improvement of Quality reporting and outcomes.

Molina's Medicaid Quality Incentive Program offers a **$75.00 Incentive Payment** (in addition to your current contract rate) for administering each of the two influenza immunizations on or between 6 months of age and the member's 2nd birthday ($150 maximum per member).

Incentive payment will be made at the time of claims payment. Please see criteria in the below chart:

Childhood Immunization Status (CIS) – Influenza Patients who received two Influenza immunization doses by their second birthday.	
CPT/HCPCS Codes	**Code Required for Incentive**
CPT: 90655, 90657, 90661, 90673-90674, 90685-90689, 90756 **HCPCS:** G0008	G8482

Billing Criteria

- Claim must include one of each code: CPT/HCPCS **AND** G8482.
- Administration of 1st Influenza Dose: Please file G8482 on the line following the Influenza vaccine CPT/HCPCS code.
- Administration of 2nd Influenza Dose: Please file G8482 on the line following the Influenza vaccine CPT/HCPCS code.
- Must file G8482 to receive each incentive payment.

To receive the incentive payment, you must administer an influenza immunization and code for such. You must also meet the following criteria:

- You must be participating in the Molina Medicaid Network as a primary care physician.
- Services for the incentive measure must be rendered between **7/1/2023** and **12/31/2023**.
- Eligible claims must be submitted no later than **2/29/2024**.
- **If your contract contains any Quality incentive language, you are not eligible for this incentive. Please reference your contract for further information.**

On behalf of Molina, thank you in advance for your support, and I look forward to your active participation in this incentive. Through our collaboration, we can continue to deliver quality care to our Molina members.
For more information, please contact your Provider Services representative.

Richard Shrouds, M.D.
Chief Medical Officer

MOLINA HEALTHCARE

Provider Services: **(855) 237-6178** Fax: **(877) 901-8182**

MolinaHealthcare.com

Quality Meetings

2024 Quality Meetings Available

Monthly or Bi-monthly

- Provider and Clinic Level Detail
- Gap In Care Report
- Call Center/Direct Scheduling
- On Site Gift Cards/Goodies
- Billing Analysis

Contact Lisa A. Collins,
Director of Provider Engagement

Email: Lisa.Collins@Molinahealthcare.com

The Advantage of Molina's Provider Resources

Scheduling Assistance

Email: Lisa.Collins@MolinaHealthcare.com

- Keonna Health Direct Scheduling
- Block Scheduling
- Molina Contact Center Outreach

Community Engagement

Email: SCCommunityEngagement@MolinaHealthcare.com

- Coat Giveaways
- Spring/ Summer Extravaganza
- Back to School Events

Targeted Campaigns

Email: Lisa.Collins@MolinaHealthcare.com

- Well Visit Days
- Vaccine Clinics
- Handle on Health

Health Educator / Case Management

Email: MHIHealthEducationMailbox@MolinaHealthCare.com

- Asthma (2+ years old)
- Sickle Cell
- Catastrophic/complex diagnosis

Standards and Guidelines

MOLINA® HEALTHCARE | You Matter to Molina

Balance Billing

Balance billing occurs when providers bill a patient for the difference between the amount they charge and the amount that the patient's insurance approves.

Balance billing Molina members for covered services is prohibited.

The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Examples of Balance Billing

- Requiring Molina members to pay the difference between the discounted and negotiated fee and the provider's usual and customary fees
- Charging Molina members fees for covered services beyond *copayments, deductibles or coinsurances

* Effective 7/1/24, Medicaid, DSNP, and MMP members are not responsible for copayments.

Access to Care Standards

In applying access standards, providers agreed they will not discriminate against any member based on age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, place of residence, socioeconomic status, or status as a recipient of Medicaid benefits. Provider and contracted medical groups may not limit the practice because of a member's medical (physical or mental) condition or the expectation of frequent or high-cost care. If a PCP chooses to close his/her panel to new members, Molina Healthcare must receive 30 days advance written notice from the provider.

Office Wait Times

- Not to exceed 45 minutes
- PCPs are required to monitor waiting times and adhere to standards

After Hours Care

- Providers must have backup (on call) coverage twenty-four hours a day, seven days a week (24/7)
- May be an answering service or recorded message
- Must instruct members with an emergency to hang up and call 911 or go to the nearest emergency room

Access to Care Standards

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

Primary Care Practitioner (PCP)	
Types of Care for Appointment	**Appointment Wait Time (Appointment Standards)**
Routine Primary Care	Within 4 weeks
Urgent Care	Within 48 hours
Emergent Visits	Immediately upon referral
Urgent Medical Condition Care	Within 48 hours of referral or notification
Routine Specialist Care	Appointment time: within 12 weeks; Wait time: within 45 minutes
Emergency Care	Immediately upon presentation at treatment site. Access by telephone for emergent medical conditions.
Walk-in Patients	Should be seen if possible. Urgent needs must be seen within 48 hours of walk-in. Non-urgent needs must be seen within routine care guideline above.
Office Wait Times	Within 45 minutes for a scheduled appointment of routine nature.
After-Hours Emergency Instructions	"If this is an emergency, please hang up and dial 911."
After-Hours Care	Available by phone 24 hours/7 days

Access to Care Standards

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

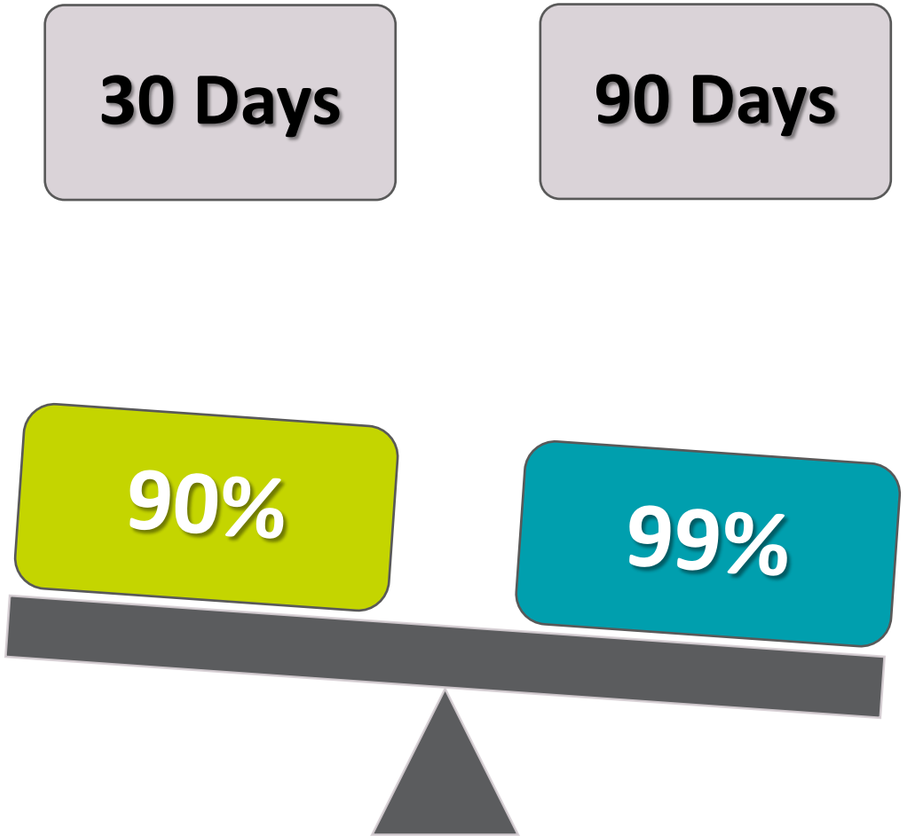
Behavioral Health	
Types of Care for Appointment	**Appointment Wait Time (Appointment Standards)**
Life Threatening Emergency	Immediately
Non-life Threatening Emergency	Within six hours of request
Urgent Care	Within 48 hours
Initial Routine Care Visit	Within 10 calendar days
Follow-up Routine Care Visit	Within 30 calendar days

Specialist Provider Care	
Types of Care for Appointment	**Appointment Wait Time (Appointment Standards)**
Emergent Visits	Immediately upon referral
Urgent Medical Condition Care	Within 48 hours of referral or notification of the PCP
Routine Care (non-symptomatic)	Within 4 weeks and a maximum of 12 weeks for unique
	specialists. Wait time: within 45 minutes

Claims Processing Standards

Claim payment will be made to contracted providers in accordance with the provisions set forth in the provider's contract. Further, payment is subject to the following minimum standards as set forth by SC DHHS.

- **90 percent** of the monthly volume of clean claims will be adjudicated within 30 calendar days of receipt by Molina Healthcare
- **99 percent** of all claims shall be paid or denied within 90 calendar days of receipt by Molina Healthcare



Health Insurance Portability and Accountability Act (HIPAA)

HIPAA requires providers to implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of a member's protected health information (PHI)		
Providers should recognize that identify theft is a rapidly growing problem and that their patients trust them to keep their most sensitive information private and confidential.	Molina strongly supports the use of electronic transactions to streamline health care administrative activities.	Providers are encouraged to submit claims and other transactions using electronic formats.

Certain electronic transactions are subject to HIPAA 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 advice

Molina is committed to complying with all HIPAA Transactions and Code Sets standard requirements. Providers who wish to conduct HIPAA standard transactions with Molina should refer to the HIPAA Transactions on our provider website.

Fraud, Waste, and Abuse (FWA)

Molina Healthcare seeks to uphold the highest ethical standards for the provision of health care services to its members and supports the efforts of federal and state authorities in their enforcement of prohibitions of fraudulent practices by providers or other entities dealing with the provision of health care services.

Fraud	Waste	Abuse
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)	Health care spending that can be eliminated without reducing the quality of care. Quality waste includes overuse, under use, and ineffective use. Inefficiency waste includes redundancy, delays, and unnecessary process complexity.	Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicare and Medicaid programs, 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 Medicare and Medicaid programs. (42 CFR § 455.2)

Do you have suspicions of member or provider fraud? The **Molina Healthcare AlertLine** is available 24 hours a day, seven days a week, and even on holidays at (866) 606-3889. Reports are confidential, but you may choose to report anonymously.

FWA

Molina is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. Molina maintains a comprehensive plan, which addresses how Molina will uphold and follow state and federal statues, and regulations.

For more information, read the “Fraud, Waste, and Abuse section of our provider manuals at MolinaHealthcare.com. Information includes:

- Introduction and Mission Statement
- Definitions
- Regulatory Requirements
- Examples of FWA by a Provider
  Examples of FWA by a Member
- Review of Provider Claims and Claims Systems
- Prepayment FWA Detection Activities
  Post-payment Recovery Activities

Do you have suspicions of member or provider fraud? The **Molina AlertLine** is available 24-hours a day, 7 days a week, and even on holidays at **(866) 606-3889**. Reports are confidential, but you may choose to report anonymously.

Examples of Provider FWA

- A provider knowingly and willfully referring members to health care facilities in which or with which the provider has a financial relationship. (Stark Law)
- Balance billing a member for covered services. This includes asking the member to pay the difference between the discounted fees, 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.
- Concealing a member's misuse of a Molina identification card.
- Inappropriate billing of modifiers 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.
- Questionable prescribing practices.
- 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 Member FWA

- Benefit sharing with persons not entitled to the member's benefits.
- Conspiracy to defraud State and Federal health care programs.
- 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 they do not suffer from and the Member sells the medication to someone else.

Do you have suspicions of member or provider fraud? The **Molina AlertLine** is available 24-hours a day, 7 days a week, and even on holidays at **(866) 606-3889**. Reports are confidential, but you may choose to report anonymously.

Molina Special Investigations Unit (SIU)

The SIU analyzes providers by using software that identifies issues such as:

- Questionable coding and/or billing patterns
- Compliance with the terms of the Provider Agreement
- Fraud, waste and abuse involving medical necessity
- Selections are random

If your practice receives a notice from the SIU:

- Cooperate with the notice and any instructions, provide requested medical records and all supporting documentation.
- Any questions, please contact your Provider Services Representative.

You may receive medical records requests from Molina or a third party on our behalf to conduct payment integrity activities. Please respond to these requests to ensure prompt, accurate adjudication.

Americans with Disabilities Act (ADA)

The Americans with Disabilities Act (ADA) prohibits discrimination against people with disabilities, including discrimination that may affect employment, public accommodations (including health care), activities of state and local government, transportation, and telecommunications. The ADA is based on three underlying values:

Compliance with the ADA extends, expands, and enhances the experience for **all** Americans accessing health care and ensures that people with disabilities will receive health and preventive care that offers the same full and equal access as is provided to others.

For more information, view the Molina Provider Education Series on the Culturally and Linguistically Appropriate Resources/Disability Resources page.

Cultural and Linguistic Expertise

National census data shows that the United States' population is becoming increasingly diverse. Molina has a thirty-year history of developing targeted healthcare programs for a culturally diverse membership and is well-positioned to successfully serve these growing populations by:

- Contracting with a diverse network of community-oriented providers who have the capabilities to address the linguistic and cultural needs of our members;
- Educating employees about the differing needs among Members; and
- Developing member education material in a variety of media and languages and ensure that the literacy level is appropriate for our target audience

Additional Cultural and Linguistic Resources are available to providers such as;

- Low-literacy materials
- Translated documents
- Accessible formats (i.e., Braille, audio or large font)
- Cultural sensitivity trainings and cultural/linguistic consultation

Cultural and Linguistic Expertise

Providers are asked to participate in and cooperate with Molina's provider education and training efforts as well as member education and efforts. Providers are also asked to comply with all health education, cultural and linguistic, and disability standards, policies and procedures.

Note – Interpretive Services

- Interpreter services are available on a 24 hour basis. Please contact Member Services toll-free at **(855) 882-3901** for more information.
- The Nurse Advice Line also provides access to 24-hour interpretive services to members
  - English line (888) 275-8750)
  - Spanish line at (866) 648-3537 or for assistance in other languages
  - *The Nurse Advice TTY is (844) 800-5155. 3901 for more information*
  - The Nurse Advice Line telephone numbers are also printed on membership cards.

Cultural and Linguistic Competency

Molina is required to provide annual Cultural Competency (CC) training to our participating provider network. Providers are required to attest to Molina the completion of CC training.

Molina offers educational opportunities in CC concepts for providers, their staff, and Community-Based Organizations.

Providers have the option to:

Utilize Molina's CC training, located on the Culturally and Linguistically Appropriate Resources/Disability Resources page of the Molina website and attest.

Utilize their own CC training that meets the federal requirement and attest to Molina.

View the Provider Training Attestation Form

Please note: Molina does not review and assess providers' training programs. Providers are mandated to complete training in compliance with the federal requirement ***and then attest to its completion***.

Deficit Reduction Act

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

Health care entities like Molina Healthcare of South Carolina who receive or pay out at least $5 million in Medicare and Medicaid funds per year must comply with DRA.

Providers doing business with Molina Healthcare of South Carolina, and their staff, have the same obligation to report any actual or suspected violation of Medicare and Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

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

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

The Federal False Claims Act and the Medicaid False Claims Act

The Federal False Claims Act and the Medicaid False Claims Act contain some overlapping language related o personal liability. For instance, the Medicaid False Claims Act has the following Triggers:

- Presents or causes to be presented to the state a Medicaid claim for payment where the person receiving the benefit or payment is not authorized or eligible to receive it
- Knowingly applies for and receives a Medicaid benefit or payment on behalf of another person, except pursuant to a lawful assignment of benefits, and converts that benefit or payment to their own personal use
- Knowingly makes a false statement or misrepresentation of material fact concerning the conditions or operation of a health care facility in order that the facility may qualify for certification or recertification required by the Medicaid program
- Knowingly makes a claim under the Medicaid program for a service or product that was not provided

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

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

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

No Surprises Act

Notice of Members' Rights and Protections Against Surprise Medical Bills

- When members get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, they are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

- When members see a doctor or other health care provider, they may owe certain out-of-pocket costs, such as a *copayment, coinsurance, and/or a deductible. Members may have other costs or have to pay the entire bill if they see a provider or visit a health care facility that isn't in the Molina Healthcare network of participating providers (or in-network).
- "Out-of-network" describes providers and facilities that haven't signed a contract with Molina Healthcare. Out-of-network providers may be permitted to bill for the difference between what the plan agreed to pay, and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count towards annual out-of-pocket limits.
- "Surprise billing" is an unexpected balance bill. This can happen when a member can't control who is involved in their care—like when they have an emergency or when thy schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

* Effective 7/1/24, Medicaid, DSNP, and MMP members are not responsible for copayments.

No Surprises Act

Members are Protected from Balance Billing for:

Emergency Services

If a member has an emergency medical condition and gest emergency services from an out-of-network provider or facility, the most the provider or facility may bill is the plan's in-network cost-sharing amount (such as *copayments or coinsurance). Members **can't** be balance billed for these emergency services. This includes services they may get after they're in stable condition, unless they give written consent and give up their protections not to be balanced billed for these post-stabilization services.

Certain Services at an In-network Hospital or Ambulatory Surgical Center

When members get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill is the plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill and may **not** ask members to give up protections not to be balance billed.

If a member gets other services at these in-network facilities, out-of-network providers **can't** balance bill, unless the member gives written consent and gives up their protections.

* Effective 7/1/24, Medicaid, DSNP, and MMP members are not responsible for copayments.

No Surprises Act

When Balance Billing isn't Allowed, Members also have the Following Protections:

They are only responsible for paying their share of the cost (like the *copayments, coinsurance, and deductibles that they would pay if the provider or facility was in-network). Molina Healthcare will pay out-of-network providers and facilities directly for covered services.

Molina Healthcare must Generally:

- Cover emergency services without requiring approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- For the services addressed in this Notice, base what is owed the provider or facility (plan cost-sharing) on what Molina Healthcare would pay an in-network provider or facility for the service and show that amount in the explanation of benefits.
- Count any amount paid for emergency services or covered out-of-network services toward the deductible and out-of-pocket limit.

Visit https://www.cms.gov/nosurprises for more information.

* Effective 7/1/24, Medicaid, DSNP, and MMP members are not responsible for copayments.

Questions

If you have questions, please reach out to your Provider Relations Representative or email SCProvider.Services@MolinaHealthcare.com.