

# **Provider Manual**

## **Molina Healthcare of Ohio, Inc.**

Thank you for your participation in the delivery of quality health care services to Molina Healthcare plan members. We look forward to working with you.

This Provider Manual shall serve as a supplement as referenced thereto and incorporated therein, to the Molina Healthcare of Ohio, Inc. Services Agreement.

The information contained within this manual is proprietary. The information is not to be copied in whole or in part; nor is the information to be distributed without the express written consent of Molina Healthcare.

The Provider Manual is a reference tool that contains eligibility, benefits, contact information and policies/procedures for services that the Molina Healthcare Medicaid and the Molina Dual Options MyCare Ohio Medicare-Medicaid Plan (MMP) specifically provides and administers on behalf of Molina Healthcare.

The Provider Manual is reviewed, evaluated and updated as needed and at a minimum annually.

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## I. **Background and Overview of Molina Healthcare, Inc. (Molina Healthcare)**

Molina Healthcare, headquartered in Long Beach, CA, is a multi-state, managed care company focused on providing health care services to people who receive benefits through government-sponsored programs. Molina Healthcare is a physician-led, family-founded health plan that believes each person should be treated like family, and that each person deserves quality care.

C. David Molina, M.D., founded the company in 1980 as a provider organization with a network of primary care clinics in California. Molina Healthcare provider networks include company-owned and operated primary care clinics, independent providers and medical groups, hospitals and ancillary providers.

As the need for more effective management and delivery of health care services to underserved populations continued to grow, Molina Healthcare became licensed as a Health Maintenance Organization (HMO) in California. Today, Molina Healthcare serves more than 2.6 million members in 11 states.

In 2010, Molina Healthcare acquired Unisys' Health Information Management Division to form Molina Medical Solutions (MMS). This business unit provides design, development, implementation and business process outsourcing solutions to state governments for their Medicaid Management Information Systems.

### A. **Molina Healthcare's Mission, Vision and Core Values**

1. **Mission** – To promote health and provide health services to families and individuals who have traditionally faced barriers to quality health, have lower income and are covered by government programs.
2. **Vision** – Molina Healthcare is an innovative health care leader providing quality care and accessible services in an efficient and caring manner.
3. **Core Values:**
  - We strive to be an exemplary organization.
  - We care about the people we serve and advocate on their behalf.
  - We provide quality service and remove barriers to health services.
  - We are health care innovators and embrace change quickly.
  - We respect each other and value ethical business practices.
  - We are careful in the management of our financial resources and serve as prudent stewards of the public funds.

### B. **Significant Growth of Molina Healthcare**

Since 2001, Molina Healthcare, a publicly traded company (NYSE: MOH), has achieved significant member growth through internal initiatives and acquisitions of other health plans. This strong financial and operational performance is uniquely attributable to the recognition and understanding that members have distinct social and medical needs and are characterized by their cultural, ethnic and linguistic diversity.

Since the company's inception more than 30 years ago, the focus has been to work with government agencies to serve low-income and special needs populations. Success has resulted from:

- Expertise in working with federal and state government agencies
- Extensive experience in meeting the needs of members
- Owning and operating primary care clinics
- Cultural and linguistic expertise
- A focus on operational and administrative efficiency

### **C. The Benefit of Experience**

Beginning with primary care clinics in California, the company grew in the neighborhoods where members live and work. This early experience impressed upon management the critical importance of community-based member education and greater access to the entire continuum of care, particularly at the times when it can do the greatest good.

Molina Healthcare has focused exclusively on serving low-income families and individuals who receive health care benefits through government-sponsored programs and has developed strong relationships with members, providers and government agencies within each regional market that it serves. Molina Healthcare's ability to deliver quality care, establish and maintain provider networks and administer services efficiently has enabled it to compete successfully for government contracts.

### **D. Administrative Efficiency**

Molina Healthcare operates its business on a centralized platform that standardizes various functions and practices across all of its health plans in order to increase administrative efficiency. Each state licensed subsidiary contracts with Molina Healthcare for specific centralized management, marketing, and administrative services.

### **E. Quality**

Molina Healthcare is committed to quality and has made accreditation a strategic goal for each of Molina Healthcare's health plans. Year after year, Molina Healthcare health plans have received accreditation from the National Committee for Quality Assurance (NCQA). The NCQA accreditation process sets the industry standard for quality in health plan operations.

## **F. Flexible Care Delivery Systems**

Molina Healthcare has structured its systems for health care delivery to be readily adaptable to different markets and changing conditions. Health care services are arranged through contracts with providers that include Molina Healthcare-owned clinics, independent providers, medical groups, hospitals and ancillary providers. Our systems support multiple contracting models, such as fee-for-service, capitation, per diem, case rates and diagnostic-related groups (DRGs).

## **G. Cultural and Linguistic Expertise**

National census data shows that the United States' population is becoming increasingly diverse. Molina Healthcare has a 30-year history of developing targeted health care 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 members
- Educating employees about the differing needs of members
- Developing member education material in a variety of media and languages and ensuring the literacy level is appropriate for our target audience

## **H. Marketing and Outreach**

Marketing creates an awareness of Molina Healthcare as an option for beneficiaries including those who are dually eligible for Medicare and Medicaid. Marketing relies heavily on community outreach efforts primarily through community agencies serving the targeted population. Brochures, billboards, physician partners, public relations and other methods are also used in accordance with the Centers for Medicare and Medicaid Services (CMS) marketing guidelines.

# **II. Eligibility, Enrollment and Disenrollment**

## **Medicaid**

Medicaid is funded by both the federal government and the state of Ohio and is administered by the Ohio Department of Medicaid (ODM).

ODM contracts with managed care plans (MCPs) to provide health care to Ohio Medicaid consumers. The state of Ohio is divided into three Medicaid managed care service areas. Molina Healthcare is contracted with ODM to serve the Medicaid population across Ohio.

A person must qualify for Medicaid benefits before he or she can enroll with a MCP. Each County Department of Job and Family Services (CDJFS) accepts applications and makes eligibility determinations. Applications are accepted online, in person and by mail.

To qualify for Medicaid, a person must meet basic requirements:

Provider Services (855) 322-4079  
www.MolinaHealthcare.com

- Be a U.S. citizen or meet Medicaid citizenship requirements
- Be an Ohio resident
- Have or get a social security number
- Meet financial requirements

Ohio has Medicaid programs for three different populations:

<b>Covered Families and Children (CFC)</b>	<b>Aged, Blind or Disabled (ABD)</b>	<b>Adult Extension (AEP)</b>
<p><i>Healthy Families</i></p> <ul style="list-style-type: none"> <li>• Children up to age 19</li> <li>• Pregnant women</li> <li>• Families with children under age 19</li> </ul>	<ul style="list-style-type: none"> <li>• Age 65 or older</li> <li>• Legally blind</li> <li>• Disabled (as classified by the Social Security Administration)</li> </ul>	<ul style="list-style-type: none"> <li>• Adults between the ages of 19 to 64, who are between 0 to 138 percent* of the Federal Poverty Level (FPL)</li> <li>• Are not eligible under another category of Medicaid</li> <li>• Parents who are between 91 to 138 percent of the Federal Poverty Level are now eligible</li> </ul>

Medicaid managed care is mandatory in the state of Ohio for all but a few exempt populations.\* Medicaid consumers are notified that they are required to choose a MCP when they receive their eligibility notice from ODM.

- To enroll in the MCP of their choice, consumers must call the state’s Medicaid Consumer Hotline at (800) 324-8680 (TTY (800) 292-3572) or visit the Medicaid Consumer Hotline website at <http://www.ohiomh.com/AvailablePlans.aspx>.
- Consumers who do not make a selection will be automatically enrolled in a MCP.
- Consumers may change their MCP for any reason within the first three months of their initial selection.
- After the first months, consumers must wait until the Open Enrollment Period to change MCPs.
- After a consumer is determined to be eligible for benefits, but before the consumer selects a MCP, the consumers can use their Fee-for-Service medical card to obtain health care services covered by Ohio Medicaid.

### **Molina Dual Options MyCare Ohio Medicare-Medicaid Plan**

Molina Dual Options MyCare Ohio Medicare-Medicaid Plan is the brand name of Molina Healthcare’s Medicare-Medicaid Plan (MMP), part of the MyCare Ohio program. Members who wish to enroll in Molina Dual Options must meet the following eligibility criteria:


- Age 18 or older at the time of enrollment
- Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits
- Eligible for full Medicaid

- Individuals eligible for full Medicaid per the spousal impoverishment rule codified at section 1924 of the Social Security Act;
- Reside in the applicable MyCare Ohio demonstration counties: Franklin, Delaware, Union, Madison, Pickaway, Clark, Greene, Montgomery, Warren, Butler, Hamilton and Clermont;
- Molina Dual Options will accept all members who meet the above criteria and elect to join the Molina Dual Options plan during appropriate enrollment periods.

### A. Member ID Cards

Molina Healthcare members receive a Molina Healthcare identification (ID) card at the time of enrollment. The member's assigned primary care provider (PCP), ID number and other important information are listed on the ID card. Members are asked to present their ID card to their provider at the time of service.

#### Molina Healthcare Medicaid


		Molina Medicaid	
Member: JOHN SMITH			
Identification #: 00000001	Date of Birth: 01/29/1965	Effective Date: 01/30/1995	
Primary Care Provider: JANE DOE			
Primary Care Provider Phone: (001) 001-0001			
BIN# BIN1 PCN# PCN1 RXGRP# RxGroup1	MMIS# 00000001	Issue Date: 01/30/2015	

**MEMBERS:** If you have any questions, please visit our website at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com) or call Member Services at (800) 642-4168 or for hearing impaired TTY/Ohio Relay (800) 750-0750 or 711, 7 a.m. to 7 p.m. Monday to Friday.  
**Transportation Services:** To arrange a ride to your appointment at no cost to you, call (866) 642-9279 or for hearing impaired TTY/Ohio Relay (800) 750-0750 or 711. Call to schedule your trip as early as possible, but at least 48 hours before your appointment.  
**24-Hour Nurse Advice Line:** If you have questions about your health, call our 24-Hour Nurse Advice Line at (888) 275-8750 or (866) 648-3537 (Spanish). For hearing impaired, call TTY (866) 735-2929.  
**Emergency Services:** Call 911 (if available) or go to the nearest emergency room or other appropriate setting. If you are not sure whether you need to go to the emergency room, call your Primary Care Provider (PCP) at the number on the front of this card for instructions. Follow up with your PCP after all emergency room visits.  
**PRACTITIONERS/PROVIDERS/HOSPITALS:** For prior authorization, eligibility, claims or benefits, visit the Molina Web Portal at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com) or call (800) 642-4168  
**Hospital Admissions:** Authorization must be obtained by the hospital prior to all non-emergency admissions.  
**PHARMACISTS:** For pharmacy questions, please call (800) 642-4168.

Claims Submission: P.O. Box 22712, Long Beach, CA 90801 - EDI Claims: WebMD-Payor #20149

[www.MolinaHealthcare.com](http://www.MolinaHealthcare.com)

#### Molina MyCare Ohio Medicaid only (opt-out)

		Molina Dual Options MyCare Ohio Medicaid	
Member Name: JOHN SMITH			
Member ID: 00000001	Health Plan ID: 80840	Medicaid ID: 00000001	
PCP Name: JANE DOE PCP Phone: (001) 001-0001			
RxBIN: BIN1 RxPCN: PCN1 RxGRP: RxGroup1			

**In Case of an Emergency:** Call 911 or go to the nearest emergency room or other appropriate setting. If you are not sure whether you need to go to the emergency room, call your Primary Care Provider (PCP). You may also contact our 24-Hour Nurse Advice Line at (888) 275-8750 TTY 711.

**Member Services:** (855) 687-7862 TTY 711 Monday - Friday 8 A.M. - 8 P.M.

**24-Hour Behavioral Health Crisis:** (888) 275-8750 TTY 711

**24-Hour Care Management:** (888) 275-8750 TTY 711

**Website:** [www.MolinaHealthcare.com/duals](http://www.MolinaHealthcare.com/duals)

Send claims to : P.O. Box 22712, Long Beach, CA 90801; Payer ID #20149



(For pharmacist use only) **Pharmacy Tech:** (800) 364-6331

**PRACTITIONERS/PROVIDERS/HOSPITALS:** For prior authorization, eligibility, claims or benefits, visit the Molina Web Portal at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com) or call (855) 322-4079

**Hospital Admissions:** Authorization must be obtained by the hospital prior to all non-emergency admissions.



## Molina Dual Options MyCare Ohio (full benefits)

 <i>Connecting Medicare+Medicaid</i>		 <small>Prescription Drug Coverage</small>	
Molina Dual Options MyCare Ohio (Medicare-Medicaid Plan)			
Member Name:	JOHN SMITH	RxBIN:	004336
Member ID:		RxPCN:	PCN1
Health Plan:	80840	RxGRP:	RxGroup1
		RxID:	
MMIS Number:	00000001		
PCP Name:	Jane Doe		
PCP Phone:	(001) 001-0001		
	H5280-001		

In an emergency, call 9-1-1 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice line.	
Member Service:	(855) 665-4623 TTY/TDD 711 Monday - Friday, 8 a.m. – 8 p.m.
Eligibility Verification:	(855) 665-4623
Behavioral Health Crisis:	(888) 275-8750
Pharmacy Help Desk:	(866) 693-4620
Care Management:	(855) 665-4623
24-Hour Nurse Advice:	(888) 275-8750 TTY/TDD (866) 735-2929 711
Website:	www.Molinahealthcare.com/duals
Send Claims To:	P.O. Box 22712, Long Beach, CA 90801 EDI Submission Payer ID 20149

### B. Verifying Eligibility

In addition to checking the member ID card, it is important to verify eligibility. To determine if a patient is eligible to receive Molina Healthcare benefits:

1. Check your current eligibility roster.
2. Log on to [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com) and log in to the [Provider Provider Portal](#).
3. Call Member Services at:
  - Medicaid: (800) 642-4168, Monday through Friday from 7 a.m. to 7 p.m.
  - Molina Dual Options (full benefits): (855) 665-4623, Monday through Friday from 8 a.m. to 8 p.m.
  - Molina MyCare Ohio Medicaid (opt-out): (855) 687-7862, Monday through Friday from 8 a.m. to 8 p.m.
4. Medicaid providers can call the ODM Interactive Voice Response (IVR) System 24 hours a day, seven days a week to confirm eligibility for MCP or Fee-for-Service Medicaid consumers. Providers must have a PIN number to access this information.

It is the responsibility of the providers to check eligibility. If the patient is not currently eligible or assigned to Molina Healthcare at the time of service, the claim will be denied. **To minimize claims payment issues, it is strongly recommended that eligibility be verified at every encounter prior to rendering the service.**

### C. Newborn Coverage for Medicaid

Effective Aug. 1, 2011, newborns of Molina Healthcare members who are enrolled in the Covered Families and Children (CFC) line of business at the time of delivery are enrolled in Molina Healthcare until the end of the month in which they are 1-year-old. Molina Healthcare notifies both CDJFS and ODM of the birth and sends reminders to enroll the newborn in Medicaid. A letter is also sent to the mother to obtain the newborn's name and desired PCP.

### D. Primary Care Provider (PCP) Assignment

Molina Healthcare members are encouraged to choose their own PCP upon enrollment. If the member or his or her designated representative does not choose a PCP, one will be assigned to the member based on reasonable proximity to the home address. MyCare Ohio Dual Options Medicaid members will not be assigned a PCP. These members will continue to use their Medicare PCP.

#### **E. PCP Changes (ABD/CFC/AEP and MMP Full Benefits members only\*)**

If for any reason the member wants to change PCPs, he or she must call Member Services to ask for the change. PCP changes are permitted every 30 days, if needed. If Molina Healthcare assigned the member to the PCP and the member calls within the first month of membership with Molina Healthcare, the change will be effective the day of the call. All other PCP changes are effective the first day of the following month. New ID cards are sent to members when a PCP change is made.

\*See the [Eligibility, Enrollment and Disenrollment section](#) for more information on Molina Healthcare plans.

#### **F. Member Disenrollment**

##### **Medicaid Disenrollment**

Members may end their membership with Molina Healthcare by contacting the Ohio Medicaid Consumer Hotline at (800) 324-8680 (TTY (800) 292-3572 or 711). Generally, if the member calls before the last 10 days of the month, his or her Molina Healthcare membership will end the first day of the next month. If the call is made in the last 10 days of the month, the membership will not end until the first day of the following month. ODM will send the member a notice in the mail to inform him or her of the day membership ends. The member must continue to use Molina Healthcare providers until the date of disenrollment.

Members may request a Just Cause termination at any time. ODM will review the request to end membership for Just Cause and decide if it meets Just Cause criteria.

Molina Healthcare may ask ODM to end a member's enrollment. ODM must approve the request before the enrollment can be ended. The reasons that Molina Healthcare can ask to terminate membership include:

- Fraud or misuse of the member's Molina Healthcare ID card.
- Disruptive or uncooperative behavior to the extent that it affects Molina Healthcare's ability to provide services to the member or other members.

##### **Molina Duals MyCare Ohio Disenrollment**

Molina Dual Options plan staff may never, verbally, in writing or by any other action or inaction, request or encourage a Molina Dual Options MMP (full benefits) member to dis-enroll except when the member has:

1. A change in residence (includes incarceration – see below) makes the individual ineligible to remain enrolled in Molina Dual Options
2. The member loses entitlement to either Medicare Part A or Part B
3. The member loses Medicaid eligibility
4. The member dies
5. The member materially misrepresents information to Molina Dual Options regarding reimbursement for third-party coverage

When members permanently move out of Molina HealthCare's service area or leave Molina HealthCare's service area for more than six consecutive months, they must disenroll from Molina Dual Options. There are a number of ways that the Molina Healthcare's Enrollment Accounting department may be informed that the member has relocated:

- Out-of-area notification received from ODM and forwarded to CMS on the monthly membership report
- Through the CMS daily transaction reply report (DTRR) file (confirms that the member has dis-enrolled)
- The member may call to advise Molina Dual Options that they have relocated, and Molina Healthcare will direct them to the Department of Healthcare Services (DHCS) for formal notification
- Other means of notification may be made through the Claims Department. If out-of-area claims are received with a residential address other than the one on file, Molina Healthcare will inform ODM so they can reach out to the member directly to begin the disenrollment process. (Molina Dual Options does not offer a visitor/traveler program to members)

Molina Dual Options will refer the member to ODM (or their designated vendor) to process disenrollment of members from the health plan only as allowed by CMS regulations. Molina Dual Options may request that a member be dis-enrolled under the following circumstances:

- Member requests disenrollment
- Member enrolls in another plan
- Member has engaged in disruptive behavior, which is defined as behavior that substantially impairs the plan's ability to arrange for or provide services to the individual or other plan members. An individual cannot be considered disruptive if such behavior is related to the use of medical services or compliance (or noncompliance) with medical advice or treatment

The following behaviors are additional reasons for disenrollment (where Molina Healthcare will notify ODM to begin the disenrollment process):

- Member abuses the enrollment card by allowing others to use it to fraudulently obtain services.

- Member leaves the service area and directly notifies Molina Dual Options of the permanent change of residence.
- Member has not permanently moved but has been out of the service area for six months or more;
- Member loses entitlement to Medicare Part A or Part B benefits;
- Member loses Medicaid eligibility.
- Molina Dual Options loses or terminates its contract with CMS. In the event of plan termination by CMS, Molina Dual Options will send CMS approved notices and a description of alternatives for obtaining benefits. The notice will be sent timely, before the termination of the plan; and/or
- Molina Dual Options discontinues offering services in specific service areas where the member resides.

In all circumstances except death, (where ODM delegates) Molina Dual Options will provide a written notice to the member with an explanation of the reason for the disenrollment; otherwise ODM (or its designated enrollment vendor) will provide a written notice. All notices will be in compliance with CMS regulations and will be approved by CMS. Each notice will include the process for filing a grievance.

In the event of death, a verification of disenrollment will be sent to the deceased member's estate.

Providers or members may contact our Member Services department to discuss enrollment and disenrollment processes and options at:

- Molina Dual Options (full benefits): (855) 665-4623 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.
- Molina MyCare Ohio Medicaid (opt-out): (855) 687-7862 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.

### **G. Managed Care Plan Exclusions**

Managed care plan (MCP) membership is not required for certain Ohio Medicaid consumers.

Children under 19 years of age have the option to be a member of a managed care plan if they are:

- Eligible for Supplemental Security Income (SSI) under Title XVI
- Receiving foster care or adoption assistance under Title IV-E
- In foster care or an out-of-home placement
- Receiving services through the Ohio Department of Health's Bureau for Children with Medical Handicaps (BCMh).

Aged, Blind or Disabled (ABD) individuals are not permitted to join a MCP if they are:

- Dually eligible under both the Medicaid and Medicare programs (not including MyCare Ohio eligible members who must enroll in an MCP)

- Institutionalized
- Eligible for Medicaid by spending down their income or resources to a level that meets the Medicaid program's financial requirements
- Receiving Medicaid waiver services (not including MyCare Ohio eligible members who must enroll in an MCP)

### III. Covered Services

- A. Molina Healthcare ensures that members have access to medically-necessary services covered by the Ohio Medicaid Fee-for-Service (FFS) program. Molina Dual Options members will have access to all medically necessary services covered by CMS and the Ohio Medicaid FFS program. This includes long-term services and supports (LTSS), community behavioral health, and services provided in a Skilled Nursing Facility (SNF). 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 wheelchair van services
- Annual physicals for adults
- Behavioral health services
- Cardiac rehab
- Chiropractic services
- Chemotherapy
- Dental services (not all inclusive)
- Dialysis
- Durable medical equipment (DME) and medical supplies (following Medicaid guidelines)
- Enteral formulas and nutritional supplements
- Family planning services and supplies
- Federally Qualified Health Center (FQHC)/Rural Health Clinic (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 facilities (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
- Telemedicine
- Transplants
- Vision care services, including eyeglasses

For detailed information on the benefits and covered services, please refer to [Appendix A](#).

## IV. **Claims and Encounter Data**

### **BILLING AND CLAIMS SUBMISSION**

The following items are covered in this section:

- [Claim Submission](#)
- [Electronic Claim Submission](#)
- [Electronic Funds Transfer \(EFT\)/Electronic Remittance Advice \(ERA\)](#)
- [Claim Corrections](#)
- [Claims Editing Process](#)
- [Claim Reconsiderations](#)
- [Coordination of Benefits](#)
- [FQHC/RHC Wrap-Around Payments](#)
- [Overpayments and Refund Requests](#)
- [Third Party Liability](#)
- [Timely Claim Filing](#)
- [Timely Claim Processing](#)

Molina Healthcare generally follows the Ohio Department of Medicaid (ODM) guidelines for claims processing and payment for the Covered Families and Children (CFC) and Aged, Blind or Disabled (ABD) programs. For MyCare Ohio, Molina Healthcare generally follows CMS billing guidelines for Medicare covered services and ODM guidelines for non-Medicare covered services.

## A. CLAIM SUBMISSION

All claims (medical and behavioral health services) should be submitted to Molina Healthcare with appropriate supporting documentation by mail or electronically.

- Molina Healthcare accepts the following claim forms:
  - [CMS 1500](#) - AMA universal claim form also known as the National Standard Format (NSF) CMS Forms List
  - [CMS 1450](#) - UB-04 (for hospitals)
- Claims for services that require prior authorization, but were not prior approved by Molina Healthcare, will be denied for no authorization.
- Providers must bill Molina Healthcare for services with the most current coding available using HIPAA-compliant transaction and code sets.

The following information must be included on every claim:

- Patient name, date of birth and ID number
- Patient gender and address
- Date(s) of service for each service rendered
- Other insurance information, as applicable
- Valid diagnosis and procedure codes
- Valid diagnosis pointers
- HIPAA-compliant CPT, HCPCS and modifier code sets
- Billed charges for each service line
- Total billed charges for the claim
- Place and type of service code
- Units, as applicable (anesthesia claims require minutes)
- Provider federal tax identification number (TIN)
- 10-digit National Provider Identifier (NPI) (All claim fields that requires provider identification) with the exception of atypical LTSS providers only.
- Rendering provider name
- Service facility location information
- Billing/pay-to provider name and address
- For prenatal or delivery services, the last menstrual period (LMP) date is required
- Valid 11-digit National Drug Code (NDC) number – required to be billed for HCPCS codes in the J series; HCPCS codes in the Q or S series that represent drugs; CPT codes in the 90281-90399 series (immune globulins); and Enteral Nutritional B Code Products that price AWP (B4157-B4162)

Claims must be legible and the information must be located in the appropriate fields on the claim form. Therefore, illegible claims will be returned to the provider, and claims lacking the information described above will be denied as incomplete.

Providers billing Molina Healthcare directly should send paper claims to:

Molina Healthcare of Ohio, Inc.  
PO Box 22712

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Long Beach, CA 90801

## B. ELECTRONIC CLAIM SUBMISSION

Molina Healthcare accepts claims electronically, including secondary claims.

- [Provider Portal](#) provider self-services at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com)
  - Register to access our online services. A video will guide you through the easy online registration process.
    - Submit claims
    - Status claims
    - Print claims reports
  - If you experience any problems with the Provider Provider Portal, please contact Molina Healthcare's Help Desk at (866) 449-6848 for technical assistance or call your Provider Services Representative directly.
- Emdeon – Electronic Data Interchange (EDI) Gateway Partner
  - Emdeon accepts all electronic claims (837P/837I) on behalf of Molina Healthcare. As a provider, you may continue to submit claims to your existing EDI clearinghouse. They will forward your files to Emdeon.
  - Providers billing Molina Healthcare electronically should use **payer number 20149**.
    - If you experience any problems with your transmission, please contact your local clearinghouse representative.

For additional information, go to Molina Healthcare's [EDI website](#) at [www.MolinaHealthcare.com/providers/common/duals/ediera/edi/Pages/benefits.aspx](http://www.MolinaHealthcare.com/providers/common/duals/ediera/edi/Pages/benefits.aspx).

Molina Healthcare encourages electronic claim submission, as it provides your office the following benefits:

- Reduces operational costs associated with paper claims
- Reduces time for Molina Healthcare to receive a claim by eliminating mailing time
- Increases accuracy of data
- Ensures HIPAA compliance

Track your electronic transmissions using acknowledgement reports to ensure that claims are received for processing in a timely manner. When your claims are filed electronically you will:

- Receive an acknowledgement from the clearinghouse
- Receive an acknowledgement from Emdeon within five to seven business days of your transmission

### ***HIPAA 5010 Transaction Compliance Standards Implementation Effective Jan. 1, 2012***

On Jan. 1, 2012, Molina Healthcare began accepting and issuing all Electronic Data Interchange (EDI) HIPAA transactions in Version 5010 format, regulated by CMS. The 4010A1 transaction standards are no longer permitted.



Molina Healthcare recommends all providers reference the appropriate ODM Companion Guide (837I, 837P), found on the ODM Trading Partner website <http://ifs.ohio.gov/OHP/tradingpartners/info.stm>, to ensure all 5010 requirements are being met to avoid any unnecessary claim rejections.

For HIPAA transaction and code set (TCS) questions or concerns, please call our toll-free HIPAA Provider Hotline at **(866) MOLINA2 [(866) 665-4622]**.

### C. **Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA)**

Molina Healthcare partnered with our payment vendor, FIS Global, for EFT/835 processing. Its web-based portal, ProviderNet, offers convenience and efficiency of electronic processes to receive both electronic payment and Electronic Remittance Advice (ERA) transmissions. We recommend our providers take advantage of ProviderNet's benefits – a free service for Molina Healthcare providers.

*Registration is easy. Follow these simple steps:*

1. Visit <https://providernet.adminisource.com> and select “Register.”
2. Verify your information.
  - a. Select Molina Healthcare from the payers list.
  - b. Enter your primary NPI, tax ID and a recent check number associated with the NPI/tax ID combination.
3. Enter your user account information and use your email address as your user name.
4. Verify your contact information, bank account information and payment address  
Note: Any changes to this address may interrupt the EFT process.
5. Sign and return the automated clearing house (ACH) form with a **voided** check from your registered account immediately.
6. Add any additional payment addresses, accounts, and tax IDs once you have logged in

Once your account is activated, you will begin receiving all payments through EFT and you will no longer receive a paper explanation of payment (EOP) (i.e. Remittance) through the mail. You will receive 835s (by your selection of routing or via manual download) and have the ability to view, print, download, and save historical and new ERA as of payment date March 28, 2011 and forward.

If you have any questions regarding the actual registration process, please contact ProviderNet customer service at (877) 389-1160 or email [Provider.Services@fisglobal.com](mailto:Provider.Services@fisglobal.com).

### D. **CLAIM CORRECTIONS**

See the [Timely Claim Filing section](#) for filing timeframe requirements to Molina Healthcare regarding corrected claims.

Corrected claim submissions are not adjustments and should be directed through the original submission process marked as a corrected claim, as outlined below, or it may result in the claim being denied.

### 1. Paper Claim Submission

- On CMS 1500s forms, indicate your submission is a corrected claim in Box 22 (Medicaid Resubmission Code) and Box 22A (Resubmission Ref No).
- On a UB04 form, indicate your submission is a corrected claim by inputting the value of 7 or 8 in Box 4 in the third digit of the Type of Bill (XX7 or XX8).
- Mail paper claims to:

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

### 2. Provider Portal Submission

- Go to <http://Provider.MolinaHealthcare.com>.
- Log in with your username and password.
- Select “Create a professional claim” from the left menu.
- Select the radio button for the correct claim option.
- Enter the ID number of the claim you want to correct.
- Make corrections and add supporting documents or an explanation of benefits (EOB).
- Submit your claim.

### 3. Electronic Submission

- In the 2300 Loop, the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:
  - “7” – REPLACEMENT (replacement of prior claim)
  - “8” – VOID (void/cancel of prior claim)
- The 2300 Loop, the REF segment (claim information), must include the original claim number of the claim being corrected, which can be found on the remittance advice.
- Bill type for UB claims are billed in loop 2300/CLM05-1. In Bill Type for UB, the 7 or 8 goes in the third digit for “frequency.”
- Molina Healthcare of Ohio payer ID for electronic submission is 20149.

To learn more, see our [Claim Features Training](#) at [www.MolinaHealthcare.com/Providers/OH](http://www.MolinaHealthcare.com/Providers/OH) under the “Manual” tab. You can also call Provider Services at (855) 322-4079 Monday through Friday from 8 a.m. to 6 p.m. for MyCare Ohio or 8 a.m. to 5 p.m. for all other lines of business.

***CMS 1500***

Claims may now be corrected using Molina Healthcare's Provider Provider Portal. Directions on how to correct or void a claim in the Provider Provider Portal can be found in the [Claims Submission Training](#) online at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com).

The request for correction to a [CMS 1500 claim form](#) must include a Molina Healthcare [Corrected Claim Form](#) or a cover letter clearly explaining the reason for the correction. [Forms](#) are available at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com).

Providers must place a 7 or 8 in box 21 of the CMS 1500 claim form. Requests for claim corrections should be mailed to:

Molina Healthcare of Ohio, Inc.  
PO Box 22712  
Long Beach, CA 90801

**E. CLAIMS EDITING PROCESS**

Molina Healthcare has a business arrangement with Verisk Health (formerly HealthCare Insight/HCI) for the screening and reviewing of professional and outpatient facility claims. Molina Healthcare has a claims pre-payment auditing process that identifies frequent correct coding billing errors such as:

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

Coding edits are based on Current Procedural Terminology (CPT), Medicaid Purchasing Administration (MPA) guidelines, industry standard National Correct Code Initiative (NCCI) policy and guidelines and industry payment rules and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

The National Correct Coding Initiative (NCCI) developed by CMS helps promote national correct coding methodologies for ensuring that claims are coded appropriately according to state and federal coding guidelines.

The coding policies developed are based on:

- Coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual
- National and local policies and edits
- Coding guidelines developed by national societies
- Analysis of standard medical and surgical practice
- Review of current coding practice

## F. CLAIM RECONSIDERATIONS

Providers seeking an adjustment of a previously adjudicated claim must request such action within 120 days of the original remittance advice unless otherwise stated in the provider contract. Requests for claim adjustments submitted after the 120-day period or the time frame specified in the provider contract cannot be considered.

In the event Molina Healthcare identifies the primary insurance information on file is incorrect, leaving Molina Healthcare as the primary carrier, the member's information will be updated and claims previously denied within 120 days of the Coordination of Benefits (COB) update will be reprocessed. Claims denied prior to 120 days of the COB update will not be reprocessed.

Refer to the [Non-Contracted Provider Billing Guidelines](#) for claim reconsideration requirements specific to non-participating providers at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com).

The request for a claim adjustment must include the following documentation to allow for a thorough review of the request:

- A completed Molina Healthcare [Claim Reconsideration Request Form](#) or a cover letter that includes the claim number and clearly explains the reason for the adjustment request.
- Additional documentation related to the claim, including the previous claim and remittance advice, a copy of the referral/authorization form (if applicable) and any other documentation to support the adjustment.
- The item(s) being resubmitted should be clearly marked as a request for an adjustment.

[Forms](#) are available at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com).

Requests for claim adjustments should be faxed to (800) 499-3406.

Claim reconsiderations need to be submitted by fax with a completed [Request for Claim Reconsideration](#) form or they will be returned to the requestor. Find the form on our website at [www.MolinaHealthcare.com/Providers/OH](http://www.MolinaHealthcare.com/Providers/OH) under the "Manual" tab.

Ninety percent of requests will be processed within 30 days of receipt. Molina Healthcare will return a response to the provider on the decision of the reconsideration request via fax whenever this number is provided. All other responses will be sent via mail to the billing address on file.

## G. COORDINATION OF BENEFITS (COB)

See the [Timely Claim Filing section](#) above for filing time frame requirements to Molina

Healthcare regarding claims with an explanation of benefits (EOB) from the primary carrier.

Medicaid pays secondary to all commercial insurance and Medicare. Commercial insurance carriers and Medicare must be billed prior to billing Molina Healthcare.

Primary insurance information can be populated on electronic claims. COB primary information can be used to pay a claim as secondary without a paper copy of the primary carrier's EOB. The following data elements must be provided on the EDI claim file:

<b>UB-04 Claims</b>	<b>CMS-1500 Claims</b>
PRIMARY PAID AMOUNT	PRIMARY PAID AMOUNT
PRIMARY ALLOWABLE	PRIMARY ALLOWABLE
TOTAL BILLED CHARGES	PATIENT RESPONSIBILITY
NON COVERED CHARGES	PATIENT PAID
TOTAL DENIED CHARGES	
PATIENT RESPONSIBILITY	

Molina Healthcare requires COB claims to be submitted as a hard copy along with a copy of the primary carrier EOB if the primary carrier either line item denied or denied the entire claim. If the claim is submitted electronically and has a line item denial or the entire claim was denied by the primary carrier, Molina Healthcare will deny for paper copy.

COB claims can be accepted electronically if the primary carrier shows an allowable and/or paid amount on the claim. Also, if the primary carrier's allowed amounts were applied to deductible, copayment or coinsurance, this information needs to be included in the data elements submitted and will be accepted electronically.

When billing paper claims, providers **must** include a copy of the primary insurance EOB with the claim.

Providers will not require members who have a primary carrier to submit secondary claims to Molina Healthcare themselves. Per [OAC 5160-26-05 Managed Health Care Programs: Provider Panel and Subcontracting Requirements](#), providers may not bill members the difference between the amount a primary carrier paid and the covered amount, even if that balance involves a copayment, coinsurance or plan deductible unless a signed waiver is on file for a non-covered Medicaid service. Should providers choose not to bill Molina Healthcare as secondary, the balance due after primary carrier has paid must be written off by the provider, which includes a member copayment, coinsurance and plan deductible.

- Molina Healthcare will pay the difference between the payment made by the primary insurance carrier and the Molina Healthcare maximum contracted allowable rate at the header level. If the primary insurance total paid amount is more than Molina Healthcare's total maximum contracted allowable amount, the claim will pay zero dollars.
- Effective Jan. 1, Medicare Part A and Part B services billed by a facility (UB form) will pay the difference between the payment made by Medicare and the Molina Healthcare maximum contracted allowable rate.
- Effective Jan. 1, 2014 for Medicare Part B professional services (1500 form), Molina Healthcare will pay the patient's responsibility when coordinating payment secondary to Medicare not to exceed Molina Healthcare's maximum contracted allowable. Include a Notice of Exclusions from Medicare Benefits (NEMB) form for a Medicare service or item that is excluded from coverage in order to process the claim.
- Molina Dual Options MyCare Ohio:
  - For Molina Dual Options members (full benefits), only one claim will be required. Molina Healthcare will adjudicate claims first under the member's Medicare benefit and second under the member's Medicaid benefit.
  - For Molina MyCare Ohio Medicaid only members (opt-out), claims will no longer cross over from Medicare. Providers will be responsible for billing Molina Healthcare for secondary payments. Molina Healthcare will not require a primary EOB for statutorily non-covered services.

### **COB Payment Methodology for Molina Dual Options MyCare Ohio**

Molina Healthcare uses both Method 2 and Method 9 for processing secondary claims under the Molina Dual Options MyCare Ohio plan. The method chosen is based on the provider type and claim type being billed for the services. Molina MyCare Ohio Medicaid only (opt-out) COB logic for members who have a Medicare managed care plan differs from the COB logic applied for members who have Fee-for-Service (FFS) Medicare.

- Method 9 or Method 2 applies to Molina MyCare Ohio Medicaid only (opt-out) claims for members who have FFS Medicare depending on the provider type.
- Method 2 applies to all Molina MyCare Ohio Medicaid only (opt-out) claims for members who have a Medicare managed care plan regardless of the provider type.

Facility claims submitted on a UB claim form, with the exception of dialysis services, are processed with COB Method 2. Dialysis claims submitted on a UB claim form are processed using COB Method 9. Professional claims submitted on a CMS 1500 claim form are processed using COB Method 9 with the exception of the following provider types, which are processed with Method 2:

- Ambulatory surgery centers
- Counselor
- DME suppliers
- Emergency transportation and non-emergency transportation providers

- Home health agencies
- Homeopath
- Hospice
- Hospital or hospital affiliated clinic
- Laboratory
- Massage therapy
- Naturopath
- Occupational therapist
- Pharmacy
- Physical/occupational therapist
- Physician assistant
- Psychologist
- Registered dietician
- Rehabilitation centers
- Skilled nursing facility
- Social workers
- Speech/hearing therapist
- Vision centers

*Method 2* – Pays the lesser of the difference between the primary payment and Molina Healthcare’s allowable, if any, or the patient responsibility, whichever is less (Medicare deductible and co-insurance). The secondary payment should not exceed the Medicaid allowable. This method is used for Medicare Part A and B facility services (UB) and claims billed on a CMS 1500 with one of the provider types listed as an exception.

*Method 9* – Calculates the secondary payment amount as the primary payer's deductible and coinsurance and compares this amount to \$0. If this amount is greater than \$0, then the deductible and coinsurance are paid. This method is used when coordinating benefits for all other Medicare Part B professional services (billed on CMS 1500 form) and dialysis facility claims billed on a UB.

### **Submitting Updated COB Information**

Complete and accurate COB information is necessary for Molina Healthcare to pay claims timely and accurately. Molina Healthcare streamlined the COB process so that it is easier for you to communicate the information with us.

If COB information has changed or termed, please submit the updated COB information directly to Molina Healthcare by sending a secure email to [MH0Enrollment@MolinaHealthcare.com](mailto:MH0Enrollment@MolinaHealthcare.com) for Medicaid members, [OHMMP\\_EnrollmentAccountingMHI@molinahealthcare.com](mailto:OHMMP_EnrollmentAccountingMHI@molinahealthcare.com) for MyCare Ohio Dual Option members or by sending a fax to (855) 714-2414 to the attention of the Enrollment Department. Remember to include:

- Molina Healthcare ID number

- A front and back copy of the other insurance ID card
- Verification of eligibility, including the member ID number and the coverage dates from the other insurance carrier or third party vendor

Health plans use the ODM [Health Insurance Fact Request Form \(JFS 06614\)](#) available at [www.odjfs.state.oh.us/forms/inter.asp](http://www.odjfs.state.oh.us/forms/inter.asp) to verify COB information.

Once you submit the COB information, Molina Healthcare will verify and adjust impacted claims that meet the standard 120-day time frame within 60 days of the submission date. Claims denied prior to 120 days of the COB update will not be reprocessed.

### **Provider Takes Reasonable Measures to Obtain Third Party Payment**

Molina Healthcare shall consider COB claims for payment when a primary carrier has not processed the claim in full when reasonable measures to obtain payment have been completed. In accordance with [OAC 5160-26-09.1 Managed Health Care Programs: Third party Recovery](#), reasonable measures are defined as follows:

- Claim submission date to the primary carrier prior to Aug. 1, 2011 and for non-contracted providers regardless of claim submission dates.
  - Provider submits a claim first to the primary carrier no less than three times within a 90-day period and does not receive a payment remit or other communication from the primary carrier within 90 days of the last submission date. Provider must provide documentation of each claim submission and date of the submission.
  - Provider submits a claim first to the primary carrier and receives a remit that states claim is awaiting payment due to non-responsiveness of member. Provider must submit documentation showing submission first to the primary carrier and at least two attempts to contact member regarding information requested from the primary carrier within a 90--day period. Provider must provide documentation of each attempt and date of the attempt.
- Claim submission date to the primary carrier Aug. 1, 2011 and after for participating providers ONLY.
  - Provider submits a claim first to the primary carrier and does not receive a payment remit or other communication from the primary carrier within 90 days after the submission date. Provider must provide documentation of the claim and date of the submission to the primary carrier.
  - Provider submits a claim first to the primary carrier and receives a remit that states claim is awaiting payment due to non-responsiveness of member and provider, then submits the documentation within 90 days of the remit denial from the primary carrier.

Acceptable documentation will include a screen print from provider's billing system. Contractual timely filing provisions still apply.



If payment from the primary carrier is received after Molina Healthcare has made payment, the provider is required to repay Molina Healthcare any overpaid amount. The provider must not reimburse any overpaid amounts to the consumer.

### Coordination of Benefits for Global Obstetrical Claims

If a primary carrier EOB is received with a global obstetrical delivery code, Molina Healthcare requires an itemized statement showing dates of service and CPT codes for:

- Prenatal visits (E&M codes – append TH modifier, if appropriate)
- Delivery
- Postpartum visits

The payment will be manually calculated to determine secondary payment. Manual calculation is necessary because global OB codes are not an Ohio Medicaid covered service. The ODM allowable for each CPT listed on the itemized statement (as long as the member was covered with Molina Healthcare at the time of service) will be multiplied by the provider's contracted rate to determine what Molina Healthcare's payment would have been if Molina Healthcare would have been primary. The primary carrier's payment is subtracted from Molina Healthcare's calculated allowable.

- If the primary carrier paid more than the Molina Healthcare allowable, no additional payment will be made.
- If the primary carrier paid less than the Molina Healthcare allowable, Molina Healthcare will pay the difference up to Molina Healthcare's allowable.

### H. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) / RURAL HEALTH CLINICS (RHCs) WRAP-AROUND PAYMENTS

Following are Molina Healthcare's Medicaid provider numbers for use when submitting documents for wrap-around payments.

Line of Business - Region	Molina Medicaid ID Numbers
Medicaid - ABD	0077182
Medicaid - CFC	0077186
Molina Dual Options MyCare Ohio Medicare-Medicaid Plan	0082414

### INVALID PLACE OF SERVICE CODES

The following place of service codes are not valid and should not be used.

<b>00</b>	Unassigned
<b>01</b>	Pharmacy
<b>02</b>	Unassigned
<b>03</b>	School
<b>04</b>	Homeless Shelter
<b>05</b>	Indian Health Service - Free standing facility

07	Tribal 638 - Free standing facility
08	Tribal 638 – Provider-based facility
09	Unassigned
10	Unassigned
18	Unassigned
27-30	Unassigned
35-40	Unassigned
43-48	Unassigned
57	Non-residential Substance Abuse Treatment Facility
58-59	Unassigned
63-64	Unassigned
66-70	Unassigned
73-80	Unassigned
82-98	Unassigned

### I. OVERPAYMENTS AND REFUND REQUESTS

In the event Molina Healthcare finds an overpayment on a claim or must recoup money, a letter requesting the refund may be mailed to the provider. The provider has 60 days to refund Molina Healthcare by check or an accounts receivable will be established and the amount of the overpayment will be deducted from the provider’s next check(s). All recovery activity will appear on your remittance advice. Use the [Return of Overpayment Form](#) to submit unsolicited refunds or check returns. [Forms](#) are available at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com).

If you have any questions regarding a refund request letter, please call the Claims Recovery Unit at (866) 642-8999 and follow the prompts to Ohio. Or, call Molina Healthcare Provider Services at (855) 322-4079.

In the event the provider receives a check that is not theirs or finds an overpayment, please send the refund with a copy of the remittance advice and claim information to:

**Please direct payment and any check, correspondence to:**

Molina Healthcare of Ohio  
 P.O. Box 715257  
 Columbus, Ohio 43271-5257

**If returning a Molina Healthcare please send to:**

Molina Healthcare of Ohio  
 P.O. Box 349020  
 Columbus, Ohio 43234-9020

### J. THIRD PARTY LIABILITY (TPL)

Molina Healthcare is required to notify ODM and/or its designated agent within 14 calendar days of all requests for the release of financial and medical records to a member or representative pursuant to the filing of a tort action. Notification must be made via the [Notification of Third Party \(tort\) Request for Release Form \(JFS 03246\)](#).

Molina Healthcare must submit a summary of financial information to ODM and/or its designated agent within 30 calendar days of receiving an original authorization to release financial claim statement letter from ODM pursuant to a tort action. Molina Healthcare must use the [Tort Summary Statement Form for ODM \(JFS 03245\)](#). Upon request, Molina Healthcare must provide ODM and/or its designated agent with true copies of medical claims.

Molina Healthcare is prohibited from accepting any settlement, compromise, judgment, award or recovery of any action or claim by the enrollee.

Molina Healthcare will pay claims for covered services when third party benefits are not available. Molina Healthcare does not recover TPL related overpayments but will notify the ODM vendor to attempt to recover any third party resources available to members and shall maintain records pertaining to TPL collections on behalf of members for audit and review.

#### **K. TIMELY CLAIM FILING**

**Original Claims:** Claims for covered services rendered to Molina Healthcare members must be received by Molina Healthcare no later than the filing limitation stated in the provider contract or within 120 days from the date of service(s). Claims submitted after the filing limit will be denied.

**Corrected Claims:** Claims received with a correction of a previously adjudicated claim must be received by Molina Healthcare no later than the filing limitation stated in the provider contract or within 120 days of the original remittance advice. Claims submitted after the filing limit will be denied.

**Coordination of Benefits:** Claims received with explanation of benefits (EOB) from the primary carrier attached must be submitted to Molina Healthcare within the greater of the above time frame or the following:

- Within 60 days of the date listed on the EOB from the other carrier for DOS prior to Aug. 1, 2011
- Within 90 days of the date listed on the EOB from the other carrier for DOS Aug. 1, 2011 and after.

The provider may request a review for claims denied for untimely filing by submitting justification for the delay as outlined in the Claim Reconsiderations section below.

Acceptable proof of timely filing must include documentation with the following:

- The date the claim was submitted
- The insurance company billed (address/payer ID) was Molina Healthcare
- The claim record for the specific patient account(s) in question

**Claim Reconsideration Requests (Disputes):** See the [Claim Reconsiderations section](#) for information and timeframes regarding review of a claim payment and/or denial.

Refer to the [Non-Contracted Provider Billing Guidelines](#) for timely filing and claim reconsideration requirements specific to non-participating providers.

#### **L. BILLING MOLINA HEALTHCARE MEMBERS**

In accordance with [OAC 5160-26-05 Managed Health Care Programs: Provider Panel and Subcontracting Requirements](#), a provider may only bill a Molina Healthcare member for:

- Non-covered services
- Services determined not to be medically necessary by Molina Healthcare's Utilization Management department if both the member and the provider sign a payment agreement *prior* to the services being rendered. The agreement must be specific to the services being rendered and clearly state:
  - The service is not covered by ODM or Molina Healthcare.
  - The service is determined not to be medically necessary by Molina Healthcare's Utilization Management department.
  - The member is choosing to receive the service and agrees to pay for it, even though the service may have been determined by Molina Healthcare to be not medically necessary.
  - The member is under no obligation to pay the provider if the service is later found to be a covered benefit, even if the provider is not paid because of non-compliance with Molina Healthcare's billing and/or prior authorization requirements.
  - For members with limited English proficiency, the agreement must be translated or interpreted into the member's primary language to be valid and enforceable. This interpretation/translation service is the responsibility of the provider to supply.
  - The written notification must be specific to the services to be provided, and clearly state the member is financially responsible for the specific service. A general patient liability statement signed by all patients at your practice does not meet this requirement.
  - The written notification must be signed and dated by the member and the date must be prior to date of service.

Please note: Billing members for missed appointments is prohibited. Molina Healthcare provides transportation to members for scheduled appointments and provides education to members regarding the importance of maintaining appointments. Providers should call Provider Services at (855) 322-4079 to determine if billing members for any services is appropriate.

#### **M. TIMELY CLAIM PROCESSING**

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 the Ohio Department of Medicaid (ODM):

- 90 percent of the monthly volume of clean claims will be adjudicated within 30 calendar days of receipt by Molina Healthcare.

- 95 percent of the monthly volume of claims shall be paid or denied within 60 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.

A clean claim is a claim that has no defect or impropriety, contains all required substantiating documentation and does not involve circumstances that require special treatment that could prevent timely payment. The receipt date of a claim is the date that Molina Healthcare receives either written or electronic notice of the claim. All hard copy claims received by Molina Healthcare will be stamped with the date of receipt.

## V. Health Care Services

### A. Introduction

Molina Healthcare maintains a medical management program to ensure patient safety as well as detect and prevent fraud, waste and abuse in its programs. The Molina Healthcare medical management program also ensures that Molina Healthcare only reimburses for services identified as a covered benefit and medically necessary. Elements of the Molina Healthcare medical management program include medical necessity review, prior authorization, inpatient management and restrictions on the use of non-network providers. For MyCare Ohio-specific Care Management questions, refer to the [MyCare Ohio Care Management section](#) of this manual.

### B. Delegation to Children's Hospital Organizations

Effective July 1, 2013, Molina Healthcare partnered with Nationwide Children's Hospital's Partners for Kids (PFK) to delegate Care Management (including complex, high-risk and medium-risk Care Management) for Children with Special Health Care Needs (CSHCN) and CFC children in their assigned counties. Members in low-risk Care Management (Disease Management) will continue to be managed by Molina Healthcare. All Utilization Management functions will continue to be handled by Molina Healthcare, as well.

**PFK Counties:** Athens, Belmont, Coshocton, Crawford, Delaware, Fairfield, Fayette, Franklin, Gallia, Guernsey, Harrison, Hocking, Jackson, Jefferson, Knox, Lawrence, Licking, Logan, Madison, Marion, Meigs, Monroe, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton, Washington

Effective July 1, 2013, Molina Healthcare also partnered with Health Network by Cincinnati Children's (HNCC) to delegate Care Management (including complex, high-risk and medium-risk Care Management) and Utilization Management for Children with Special Health Care Needs (CSHCN) and CFC children in their assigned counties. Behavioral Health Care Management is currently excluded. Members in low-risk Care Management (Disease Management) will continue to be managed by Molina Healthcare. HNCC will handle all Utilization Management functions, including pre-certification,

inpatient concurrent review, retro-authorization and reconsideration of denied services as indicated. Utilization Management of Behavioral Health Services, including both inpatient and outpatient services, are currently being managed by Molina Healthcare.

**HNCC Counties:** Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland and Warren

Each organization will work only with members in their specific regions or counties. Appeals and Grievances for both hospital systems will continue to be managed by Molina Healthcare.

### **C. Medical Necessity Review**

In conjunction with regulatory guidance from CMS and industry standards, Molina Healthcare only reimburses services provided to its members that are medically necessary. Molina Healthcare may conduct a medical necessity review of all requests for authorization and claims within the specified time frame governed by federal or state law for all lines of business. This review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively, as long as the review complies with federal or state regulations and the Molina Healthcare Hospital or Provider Services Agreement.

#### **Clinical Information**

Molina Healthcare requires copies of clinical information be submitted for documentation in all medical necessity determination processes. Clinical information includes but is not limited to physician emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations and therapist notes. Molina Healthcare does not accept clinical summaries, telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless required by state regulation or the Molina Healthcare Hospital or Provider Services Agreement.

### **D. Prior Authorization (PA)**

Molina Healthcare requires prior authorization (PA) for specified services as long as the requirement complies with federal or state regulations and the Molina Healthcare Hospital or Provider Services Agreement. The list of services that require PA is available in narrative form as the [Service Request Form and Instructions](#), as well as a more detailed list by CPT and HCPCS codes called the [CPT Codes Requiring Prior Authorization](#). Molina Healthcare PA documents are updated annually and the current documents are posted on the Molina Healthcare website at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com). Molina Healthcare has included at the end of this section a copy of the current [Authorization Request Form](#). If using a different form, the PA request must include the following information:

- Member demographic information (name, date of birth, Molina Healthcare ID number, etc.)

- Provider demographic information (referring provider and referred to provider/facility)
- Requested service/procedure, including all appropriate CPT, HCPCS and ICD-9 codes
- Clinical information sufficient to document the medical necessity of the requested service

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by federal and state law) are excluded from the PA requirements. Molina Healthcare does not retroactively authorize services that require PA.

Molina Healthcare and its delegated entity Health Network by Cincinnati Children's will process any non-urgent requests within 14 calendar days of receipt of request. Urgent requests will be processed within 72 hours.

Providers who request PA approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting provider at (855) 322-4079. For Health Network by Cincinnati Children's members, providers may call (855) 789-4622 from 8:30 a.m. to 5 p.m., Monday through Friday.

### **Requesting Prior Authorization**

**Provider Provider Portal/Clear Coverage™:** Providers are encouraged to use the Molina Healthcare Provider Provider Portal for PA submission. When submitting a request for outpatient services, Molina Healthcare has a rules-based authorization submission process called Clear Coverage™. When you log in to the Provider Portal, choose the drop down option "Create Service Request/Authorization using Clear Coverage™" under the "Service Request/Authorization Menu." Currently, the rules-based authorization submission process is for outpatient services. Clear Coverage™ is available for MyCare Ohio.

Some of the benefits of using Clear Coverage™ are:

- Many outpatient services can automatically be approved at the time of the authorization submission.
- For requests not automatically approved, you can see the real-time status of your request by opening your office's home page directly in Clear Coverage™.
- Receive rapid confirmation for services where no authorization is required. You are notified within a few steps if no authorization is required for the CPT code requested. You can print or paste a copy of that notification showing no authorization required for your records. There is no need for you to take any additional action.

### **Prior Authorization Guidelines and Request Form**

Visit the Molina Healthcare website at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com) for guidelines, the PA request form and a codified list of all services that require a PA. On the Forms page, scroll down to “Medical Services” to find the [Service Request Form and Instructions](#) or choose [CPT Codes Requiring Prior Authorization](#) for a codified list.

- **Fax:** The PA form can be faxed to Molina Healthcare at (866) 449-6843. If the request is not on the form provided in this manual, be sure to send to the attention of the Health Care Services department.
  - For Molina Dual Options MyCare Ohio, providers may fax to (877) 708-2116.
  - For Behavioral Health authorizations, providers may fax to (866) 553-9262.
  - For Health Network by Cincinnati Children’s members, providers may fax to (877) 402-8646.
- **Clear Coverage™:** McKesson’s Clear Coverage™ is a web-based system that provides an automated method for providers and health plans to manage authorization for services at the point-of-care. Clear Coverage™ provides the following benefits:
  - Automatic authorization
  - Immediate proof of authorization
  - Flexibility to submit requests 24/7
  - Minimal need for phone calls or faxes
  - Ability to attach medical records
  - Printable confirmation with authorization number
  - Clinical decision support:
    - Interactive tool with InterQual Criteria
    - Confirms evidence basis for requested services
    - Transparency to medical necessity criteria
    - Integrated coverage determination
    - Eligibility check
    - Benefits information; rules are embedded in the application if an authorization is required for a specific service
    - In-network steering and confirmation
- **Mail:** PA requests and supporting documentation can be submitted via mail at the following address:

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

## **E. Inpatient Management**

**Elective Inpatient Admissions** – Molina Healthcare requires PA for all elective inpatient admissions to any facility. Elective inpatient admission services performed without PA may not be eligible for payment.



**Emergent Inpatient Admissions** – Molina Healthcare requires notification of all emergent inpatient admissions within 24 hours of admission or by the close of the next business day when emergent admissions occur on weekends or holidays. Molina Healthcare requires that notification includes member demographic information, facility information, date of admission and clinical information (see definition above) sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting notification and medical necessity requirements will result in a denial of authorization for the inpatient admission.

**Concurrent Inpatient Review** – Molina Healthcare performs concurrent inpatient review in order to ensure patient safety, medical necessity of ongoing inpatient services, and adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. Molina Healthcare will request updated original clinical records from inpatient facilities at regular intervals during a member's inpatient admission. Molina Healthcare requires that requested clinical information updates be received from the inpatient facility within 24 hours of the request. Failure to provide timely clinical information updates will result in denial of authorization for the remainder of the inpatient admission.

### **Inpatient Observation Policy**

Molina Healthcare has implemented inpatient utilization review policy changes effective Oct. 1, 2013. The goal is to ensure members receive medically necessary services in the appropriate and most efficient and cost effective setting. All inpatient admissions require PA. Similar to [Ohio Administrative Code \(OAC\) 5160-26-03](#), Molina Healthcare will review and evaluate covered medical services to ensure procedures are medically necessary and provided in the most appropriate setting.

If inpatient admission InterQual<sup>®</sup> criteria are not met and observation InterQual<sup>®</sup> criteria are met, Molina Healthcare will authorize an observation stay. For stays of one day or less, when InterQual<sup>®</sup> is met for inpatient and observation, Molina Healthcare will review and consider these for observation level of care. If you disagree with the decision and believe inpatient admission is necessary, a Molina Healthcare Medical Director will review the case and make a determination.

**Important Note: Hospitals participating in Molina Healthcare's network are not required to seek authorization for observation days.**

- If both observation and inpatient criteria are met, Molina Healthcare will initially authorize an observation stay for the following conditions:
  - Acute abdomen
  - Acute appendicitis (adult)
  - Acute bronchitis
  - Acute coronary syndrome/chest pain
  - Acute kidney failure
  - Acute pancreatitis

- Anemia asthma bronchiolitis
- Cardiac dysrhythmia
- Cellulitis or abscess
- Cholelithiasis
- Chronic ischemic heart disease
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Deep vein thrombosis (DVT) dehydration
- Diabetes/Diabetic Ketoacidosis (DKA)
- Disorders of fluid, electrolyte, and acid base balance (nausea, vomiting)
- Gastroenteritis/esophagitis
- General symptoms
- Hypotension
- Pneumonia, organism unspecified or Simple
- Poisoning/toxic ingestions
- Seizures
- Septicemia
- Syncope or decreased responsiveness
- Unstable angina

These conditions are often evaluated and treated within one day or less and rapid improvement of the member's condition is anticipated. If the member remains hospitalized past one day and continues to meet InterQual<sup>®</sup> criteria, Molina Healthcare will approve the inpatient admission authorization request. If inpatient admission InterQual<sup>®</sup> is met, Molina Healthcare will approve an inpatient admission based upon clinical criteria at the time of admission, excluding the above listed conditions. For instructions on submitting a PA request, visit [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com).

#### **F. Non-Network Providers**

Molina Healthcare maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process in order to provide medical care for Molina Healthcare members. Molina Healthcare requires members to receive medical care within the participating, contracted network of providers. All care provided by non-contracted, non-network providers must be prior authorized by Molina Healthcare. Non-network providers may provide emergent/urgent care and dialysis services for a member who is temporarily outside the service area, without PA or as otherwise required by federal or state laws or regulations.

#### **G. Avoiding Conflict of Interest**

The Health Care Services department affirms its decision-making is based on appropriateness of care and service and the existence of benefit coverage.

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

utilization. Also, we require our delegated medical groups/Independent Practice Associations (IPAs) to avoid this kind of conflict of interest.

#### **H. Coordination of Care**

Molina Healthcare's Integrated Care Management, which includes Utilization Management, Care Management and Disease Management, will work with providers to assist with coordinating services and benefits for members with complex needs and issues. It is the responsibility of contracted providers to assess members and, with the participation of the member and their representatives, create a treatment care plan. The treatment plan is to be documented in the medical record and is updated as conditions and needs change.

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

#### **I. Continuity of Care and Transition of Members**

It is Molina Healthcare's policy to provide members with advance notice when a provider they are seeing will no longer be in network. Members and providers are encouraged to use this time to transition care to an in-network provider. The provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the provider(s) assuming care. Under certain circumstances, members may be able to continue treatment with the out-of-network provider for a given period of time. For additional information regarding continuity of care and transition of members, please contact Molina Healthcare at (855) 322-4079

#### **MyCare Ohio Transition of Care (TOC) Period**

The Utilization Management and Care Management staffs facilitate the transition of care (TOC) for members whose benefits have come to end. Alternatives to coverage are explored with the member, the PCP, community resources and any new coverage to ensure continuity of care. A complete list of the TOC timeframes surrounding the MyCare Ohio demonstration can be found in [Appendix B](#) of this manual.

#### **J. Continuity and Coordination of Provider Communication**

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

#### **K. Readmission Policy**

Hospital readmissions, defined by [OAC 5160-2-02 General Provisions: Hospital Services](#) as less than 31 calendar days from the date of discharge, have been found by ODM to

potentially constitute a quality of care problem. Readmission review is an important part of Molina Healthcare's Quality Improvement Program to ensure Molina Healthcare members are receiving hospital care that is compliant with nationally recognized guidelines, as well as federal and state regulations.

Molina Healthcare will conduct readmission reviews according to [OAC 5160-2-07.13 Utilization Control](#) for applicable participating hospitals if both admissions occur at the same facility. If it is determined that the subsequent admission is related to the first admission ("readmission"), the first payment may be considered as payment in full for both the first and second hospital admissions. Readmission reviews will be conducted in accordance with ODM guidelines.

#### **L. Care Management**

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

The Molina Healthcare Care Managers are licensed professionals and are educated, trained and experienced in the Care Management process. The CM program is based on a member advocacy philosophy, designed and administered to assure the member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes.

The CM program is individualized to accommodate a member's needs with collaboration from the member's PCP. The Molina Healthcare Care Manager will arrange individual services for members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina Healthcare Care Manager is responsible for assessing the member's appropriateness for the CM program and for notifying the PCP of the evaluation results, as well as making a recommendation for a treatment plan.

*Referral to Care Management:* members with high-risk medical conditions may be referred by their PCP or specialty care provider to the CM program. In addition, CM accepts referrals from hospitals, nursing homes, and other health care providers as well as internal referrals. The Care Manager works collaboratively with all members of the health care team, including the PCP, hospital Utilization Management staff, discharge planners, specialist providers, ancillary providers, the local Health Department and other community resources. The referral source may provide the Care Manager with demographic, health care and social data about the member being referred.

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

- High-risk pregnancy, including members with a history of a previous preterm delivery
- Catastrophic medical conditions (e.g. neoplasm, organ/tissue transplants)
- Chronic illness (e.g. asthma, diabetes, end stage renal disease)
- Preterm births
- High-technology home care requiring more than two weeks of treatment
- Member accessing emergency room (ER) services inappropriately
- Children with Special Health Care Needs (CSHCN)

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

Phone: (855) 322-4079

Fax: (866) 553-9260

### **PCP Responsibilities in Care Management Referrals**

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

### **Care Manager Responsibilities**

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

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

## **M. MyCare Ohio Care Management**

### **a. Risk Stratification**

Molina Healthcare identifies at-risk members who may benefit from Care Management through an analysis of all available data, which may include encounter forms, claims data, member health risk assessments and pharmacy claims, data provided by CMS and/or, ODM as well as through internal and external referrals. The

selection criteria are based on the current literature and Molina Healthcare's experience with its members, creating a focused, results-oriented approach to identification and interventions.

For higher need members, the selection criteria include one or more of the following:

- Recent utilization for selective chronic conditions
- Several co-morbidities
- High-risk maternity
- History of high costs

Selection criteria for members with lower level needs include:

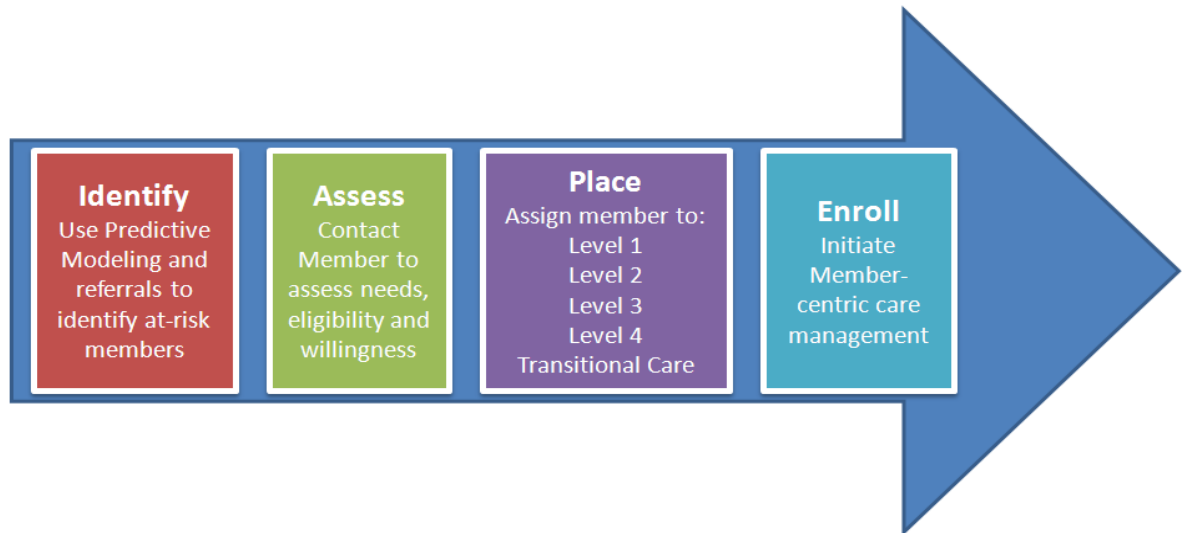
- Request for or existing use of Long-Term Supports and Services (LTSS)
- Recent utilization for selective chronic conditions
- Pharmacy utilization
- Abnormal lab results
- Missed preventive services
- Other health management needs such as smoking cessation or weight management

These criteria define the trigger lists which are then prioritized using member prospective risk scores from Molina Healthcare's current predictive modeling tool. Prioritization is further refined to include admission and emergency department visit counts, co-morbidity counts, and high cost amounts. Molina Healthcare members will benefit from this prioritization process since immediate attention is focused on those who are in greatest need and likely to benefit from intensive Care Management.

In addition, referrals of at-risk members may come from providers, internal Molina Healthcare resources such as the 24-Hour Nurse Advice Line, or from the members themselves.

Members identified through these various channels as potentially requiring Care Management services are then contacted by a Molina Care Healthcare Care Manager to further assess their unique needs and verify if enrollment in Care Management is appropriate. This process includes assigning the level of care to the member based on applying clinical protocols and conducting assessments.

To further refine and streamline the risk-stratification process, Molina Healthcare continues to explore innovative solutions, including cutting edge predictive modeling technology.



Each member identified as being at-risk is evaluated through a risk stratification process to determine the appropriate level of intervention needed:

- Health Management
- Care Management
- Complex Care Management

For all levels, the focus of the interventions is to provide member education and/or to coordinate access to services that clinical peer-reviewed literature and Molina Healthcare's own multi-decades of experience have shown improve health outcomes. The intensity of interventions provided increases for each subsequent level.

Molina Healthcare has conducted extensive research of current literature to identify the factors that increase the likelihood of hospitalization, costly medical expenses, or poor health outcomes for members. Using this information, Molina Healthcare has updated its criteria that trigger member placement into the various levels of Care Management. All Molina Healthcare state health plans are currently using the updated list of Care Management triggers and the three new Care Management levels.

Based on the level of Care Management needed, outreach is made to the member to determine the best plan to achieve short- and long-term goals. Each level of the HCS program has its own specific health assessment used to determine interventions that support member achievement of short- and long-term goals. At the higher levels, this includes building an individualized care plan with the member and/or representative. These assessments include the following elements based on NCQA, state and federal guidelines:

- Health status and diagnoses
- Clinical history
- Medications prescribed
- Activities of daily living, functional status, need for or use of LTSS
- Cultural and linguistic needs

- Visual and hearing needs
- Caregiver resources
- Available benefits and community resources
- Life-planning activities (e.g., health care power of attorney, advance directives)
- Body mass index (BMI)
- Smoking
- Confidence
- Readiness to change
- Member's desire and interest in self-directing his or her care
- Communication barriers with providers
- Treatment and medication adherence
- Emergency department and inpatient use
- PCP visits
- Living situation
- Psychosocial needs (e.g., food, clothing, employment)
- Durable medical equipment needs
- Health goals
- Mental health
- Chemical dependency

The resulting care plan is approved by the member, may be reviewed by the Interdisciplinary Care Team (ICT), and maintained and updated by the Care Manager as the member's condition changes. The Care Manager also addresses barriers with the member and/or caregiver and collaborates with providers to ensure the member is receiving the right care, in the right setting, with the right provider.

The purpose of the HCS program interventions at all levels is to ensure that the member and/or family understands and agrees with the care plan, understands the member/family/physician/Case Manager role in fulfilling the care plan, understands key self-management concepts and has the resources for implementation. All member education is consistent with nationally-accepted guidelines for the particular health condition.

### **Level 1 – Health Management**

Health Management is focused on disease prevention and health promotion. It is provided for members whose lower acuity chronic conditions, behavior (e.g., smoking or missing preventive services) or unmet needs (e.g., transportation assistance or home services) put them at increased risk for future health problems and compromise independent living. The goal of Health Management is to achieve member wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation throughout the continuum of care.

At this level, members receive educational materials via mail about how to improve lifestyle factors that increase the risk of disease onset or exacerbation. Topics covered



include smoking cessation, weight loss, nutrition, exercise, hypertension, hyperlipidemia, and cancer screenings, among others. Members are given the option to engage in telephone-based health coaching with Health Management staff, which includes nurses, social workers, dieticians and health educators.

The table below outlines the key triggers that result in a member’s placement into Level 1 – Health Management and the possible interventions. The triggers and interventions listed are not all inclusive. A member may be placed in this level based on other clinical needs or provider recommendation. If at any time a member requires a different level of care, a reassessment of risk is conducted and a new plan is made for the administration of the appropriate level of interventions.

Triggers for Health Management	Interventions
<p>Member has one inpatient admission or three emergency department visits within the previous six consecutive months with specific conditions.</p> <p>Targeted diagnoses include:</p> <ul style="list-style-type: none"> <li>• Asthma</li> <li>• Cardiovascular</li> <li>• Congestive heart failure (CHF)</li> <li>• Chronic obstructive pulmonary disease (COPD)</li> <li>• Diabetes</li> </ul> <p>Member exhibits need for any of the following:</p> <ul style="list-style-type: none"> <li>• Education support for health care/ pharmacotherapy</li> <li>• Home- and community-based services</li> <li>• Transportation assistance</li> <li>• High-risk social/behavioral health or substance abuse services</li> <li>• Smoking cessation</li> <li>• Dietary assistance</li> <li>• Outreach regarding HEDIS® missed services</li> </ul>	<p>Interventions customized to member’s needs may include:</p> <ul style="list-style-type: none"> <li>• Health education</li> <li>• Medication education to ensure adherence to appropriate pharmacotherapy treatment plans</li> <li>• Healthy lifestyle management techniques</li> <li>• Informational booklets for key conditions (e.g., COPD, depression, diabetes)</li> <li>• Service coordination including transportation coordination, appointment scheduling and durable medical equipment coordination</li> <li>• Referral to community or external resources</li> <li>• Behavioral health coordination</li> </ul>

### **Level 2 –Care Management**

Care Management is provided for members who have medium-risk chronic illness requiring ongoing intervention. These services are designed to improve the member’s health status and reduce the burden of disease through education and assistance with the coordination of care including LTSS. The goal of Care Management is to collaboratively assess the member’s unique health needs, create individualized care plans with prioritized goals and facilitate services that minimize barriers to care for optimal health outcomes. Care Managers have direct telephonic access with members. In addition to the member, Care Management teams also include pharmacists, social

workers and behavioral health professionals who are consulted regarding patient care plans. In addition to telephonic outreach to the member, the Care Manager may enlist the help of a community health worker or a Community Connector to meet with the member in the community for education, access or information exchange.

The table below outlines the key triggers that result in a member’s placement into Level 2 – Care Management and the possible interventions. The triggers and interventions listed are not all inclusive. A member may be placed in this level based on other clinical needs or provider recommendation.

Triggers for Care Management	Interventions
<p>Member exhibits any of the following:</p> <ul style="list-style-type: none"> <li>• Predictive modeling risk score</li> <li>• Two inpatient admissions and three emergency department visits within the previous six consecutive months</li> <li>• Range of three to four co-morbidities.</li> <li>• Targeted diagnoses include:               <ul style="list-style-type: none"> <li>○ Asthma</li> <li>○ AIDS/HIV</li> <li>○ Cancer (other than chemotherapy admissions)</li> <li>○ Cardiovascular</li> <li>○ CHF</li> <li>○ COPD</li> <li>○ Diabetes</li> <li>○ End-stage renal disease</li> <li>○ Sickle cell anemia</li> <li>○ High-risk pregnancy or newborn</li> <li>○ Mental health diagnoses</li> <li>○ Chemical dependency</li> </ul> </li> </ul>	<p>Interventions customized to member’s needs include:</p> <ul style="list-style-type: none"> <li>• Use of standardized assessments to determine member needs</li> <li>• Development of care plan with prioritized goals</li> <li>• Ongoing telephonic member contact</li> <li>• Care coordination including mental health, chemical dependency and LTSS</li> <li>• Focused health education and coaching to promote self-management</li> <li>• Coordinated interdisciplinary approach involving internal staff, providers, member/family and community resources</li> <li>• Service coordination including arranging transportation, scheduling appointments and attaining durable medical equipment</li> <li>• Referral to community or external resources</li> </ul>

### **Level 3 – Complex Care Management**

Complex Care Management is provided for members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the health care system to facilitate the appropriate delivery of care and services.

The goal of Complex Care Management is to help members improve functional capacity and regain optimum health in an efficient and cost-effective manner. Comprehensive assessments of member conditions include the development of a Care Management plan with performance goals and identification of available benefits and

resources. Care Managers monitor, follow up on and evaluate the effectiveness of the services provided on an ongoing basis. Complex Care Management employs both telephonic and face-to-face interventions.

The table below outlines the key triggers that result in a member’s placement into Level 3 – Complex Care Management and the possible interventions. The triggers and interventions listed are not all-inclusive. A member may be placed in this level based on other clinical needs or provider recommendation.

Triggers for Complex Care Management	Interventions
<p>Member exhibits any of the following:</p> <ul style="list-style-type: none"> <li>• Predictive modeling risk score</li> <li>• High-risk chronic illness with clinical instability as demonstrated by three or more admissions or six or more emergency department visits within a six-month period</li> <li>• Five or more co-morbidities</li> <li>• Targeted diagnoses include:               <ul style="list-style-type: none"> <li>○ Asthma</li> <li>○ AIDS/HIV</li> <li>○ Cancer (other than chemotherapy admissions)</li> <li>○ Cardiovascular</li> <li>○ CHF</li> <li>○ COPD</li> <li>○ Diabetes</li> <li>○ End-stage renal disease</li> <li>○ Sickle cell anemia</li> <li>○ Mental health diagnoses</li> <li>○ Chemical dependency</li> </ul> </li> <li>• Expected annual expenditures of \$100,000 or greater</li> </ul>	<p>Interventions customized to member’s needs include:</p> <ul style="list-style-type: none"> <li>• Use of standard assessments to determine member needs</li> <li>• Development of care plan with prioritized goals</li> <li>• Ongoing telephonic and face-to-face member contact, including home visits</li> <li>• Care Coordination with mental health, chemical dependency and LTSS</li> <li>• Focused health education and coaching to promote self-management</li> <li>• Coordinated interdisciplinary approach involving internal staff, providers, member/family and community resources</li> <li>• Service coordination including arranging transportation, scheduling appointments, and attaining durable medical equipment</li> <li>• Coordination with community-based organizations and services for housing, food assistance, supported employment, etc.</li> </ul>

**Level 4 – Imminent Risk**

Level 4 – Imminent Risk focuses on members at imminent risk of an emergency department visit, an inpatient admission or institutionalization and offers additional high-intensity, highly-specialized services. Level 4 also includes those members who

are currently institutionalized but qualify to transfer to a home or community setting. Populations most often served in Level 4 are the Medicare-Medicaid dual-eligible, those with severe and persistent mental illness (SPMI), those with dementia and those who are developmentally delayed. These services are designed to improve the member's health status and reduce the burden of disease through education as described in Level 1 – Health Management.

These criteria include:

- Meeting an intensive skilled nursing (ISN) level of care
- Facing an imminent loss of current living arrangement
- Deterioration of mental or physical condition
- Having fragile or insufficient informal caregiver arrangements
- Having a terminal illness
- Having multiple other high risk factors

Comprehensive assessments of Level 4 conditions include assessing the member's unique health needs using the comprehensive assessment tools, identifying potential transition from facility and need for LTSS referral coordination, participating in ICT meetings, creating individualized care plans with prioritized goals and facilitating services that minimize barriers to care for optimal health outcomes.

Level 4 Identification Criteria:

High-risk chronic illness with clinical instability as demonstrated by five or more admits in six months related to:

- CVD
- CHF
- COPD
- End State Renal Disease (ESRD)
- Asthma
- Diabetes
- Sickle Cell
- AIDS/HIV
- Cancer
- Behavioral health (specific codes)
- Imminent risk of:
  - Inpatient admission (psychiatric or medical) related to inability to self-manage in current living environment
  - Institutionalization (state psychiatric hospital or nursing home):
- Needs assistance with four or more activities of daily living and independent activities of daily living and lacks adequate care giver assistance
- Long-term nursing facility residents with potential to transition safely to community setting
- Hospice services

Triggers for Imminent Risk Care Management	Interventions
Member exhibits any of the following: <ul style="list-style-type: none"> <li>• Loss of current living arrangement</li> <li>• Deterioration of mental or physical condition</li> <li>• Fragile or insufficient informal caregiver arrangements</li> <li>• Terminal illness</li> <li>• Multiple other high-risk factors</li> </ul>	Interventions customized to member's needs include: <ul style="list-style-type: none"> <li>• Referral for housing assistance</li> <li>• Arrangements for private duty nursing or aid assistance</li> <li>• Hospice</li> <li>• Individualized member care plan</li> <li>• LTSS referral and coordination</li> </ul>

**b. MyCare Ohio Transitions Program**

Molina Healthcare's goal is to have our providers work closely with the Transition of Care (TOC) team to ensure that our members understand and are able to manage their medications, understand the signs and symptoms of their disease process, and know when to call their PCP. In addition, the Care Transition Coaches will mail out personal health records and other member-specific information to each member's PCP. We request that the practitioner review this information and communicate any questions or concerns they may have related to supporting our members through the care transition process back to the Care Transition Coach.

To contact the TOC team, please call (855) 322-4079.

Molina Healthcare defines the Transitions Program to include all services required to ensure the coordination and continuity of care from one care setting to another as the member's health status changes. This is accomplished by providing members with the tools and support that promote knowledge and self-management of their condition and by facilitating improved member and provider understanding of roles, expectations, schedules and goals. Such transitions occur, for example, when a member moves from a home to a hospital as the result of an exacerbation of chronic conditions or moves from a hospital to a rehabilitation facility after surgery.

Molina Healthcare has two Transitions Programs:

*Transitions of Care Telephonic Coaching Program* – designed to reach a larger volume of high-risk members by attempting one inpatient hospital outreach call and, at a minimum, three subsequent phone calls within a four- to six-week period of time from the date of the member's initial admission.

*Health Care Transitions Program* – designed for members to receive two face-to-face contacts – one in the hospital prior to discharge and one at home within 48 hours of discharge. Targeted at members known to have admitting diagnoses, which research has shown have the highest risk for readmission to an inpatient facility.

Both programs are administered by a Molina Healthcare clinical team member in order to facilitate the transition and to coordinate needed services with appropriate providers.

As Molina Healthcare works with hospitals in demonstrating the increased value of the Transitions Program in preventing hospital readmissions, all TOC activity will move into the face-to-face model.

The aim of the Transitions Program includes:

- Preventing hospital readmission
- Optimal transitioning from one care setting to another
- Identifying an unexpected change in condition requiring further assessment and intervention.

Continuity of care post discharge communications may include, but not be limited to, phone calls and follow-up letters to members and their PCPs, specialty providers, other treating providers/practitioners, as well as agencies providing LTSS.

The Molina Healthcare Transitions Program re-establishes the member's connection to his or her medical home by ensuring that an appointment has been scheduled with the member's PCP prior to discharge from a hospital. The goal is to arrange an appointment to occur within seven days of discharge. Follow-up phone calls will also be made to support the member.

The transition program will operate within a 30-day framework. Once the care transition process is complete and it is determined the member has ongoing needs, a designated Molina Healthcare Care Manager will work with the member to address those needs going forward.

Molina Healthcare will also obtain releases from members when necessary to ensure HIPAA compliance and allow for sharing of relevant information necessary for transitions in care.

#### Purpose of Molina Healthcare's Transitions Program

- Effectively transition members from one setting to another by improving member and provider understanding of roles, expectations and goals.
- Fully prepare members to continue care plans from one setting to another, including awareness of the schedule of events, process awareness and points of contact.
- Facilitate the four fundamental elements (described below) designed to produce positive outcomes targeted to improve member health.
- Assist members through transitions and coordinate needed services with appropriate providers.

- Promote member self-management while encouraging empowerment by embracing the concept of “consumer direction” to encourage members to direct their care through personal choice and responsibility.
- Engage members directly so they can retain an active voice in planning treatment and find satisfaction in the process as it develops.

The Molina Healthcare Transitions Program focuses on four critical elements as the foundation to prepare members for successful transitions, adapted from Dr. Eric Coleman’s Model of Care Transitions Interventions ([www.caretransitions.org](http://www.caretransitions.org)) (Eric A. Coleman, MD, MPH).

**Medication Management** – Molina Healthcare’s transition staff will assist with the coordination of member medication authorizations as appropriate, provide training to members regarding their medications and conduct medication reconciliation to avoid inadvertent medication discrepancies. Through its Pharmacy Benefit Manager (PBM), CVS Caremark, Molina Healthcare will have up-to-date information readily available regarding the member’s current medications and medication history.

**Personal Health Record** – Molina Healthcare’s transitions staff will assist with completion of a portable document with pertinent member history, provider information, discharge checklist and medication record to ensure continuity across providers and settings.

**PCP and/or Specialist Appointments** – Molina Healthcare transitions staff will facilitate appointment scheduling and transportation to ensure members keep follow-up appointments and will help members understand their Personal Health Record and medication record.

**Knowledge of Red Flags** – Molina Healthcare’s transitions staff will ensure members are knowledgeable about and aware of indications that their condition is worsening and how to respond.

**Molina Healthcare Transitions Program Targeted Diagnoses:**

The target population for the Molina Healthcare Transitions Program will include members admitted with the following diagnoses, which research has shown present the highest risk for re-admission to an inpatient facility:

- Asthma
- Cellulitis
- COPD
- CHF
- Diabetes
- Pneumonia
- History of serious psychological impairment (psychosis, schizophrenia, bipolar disorder)

Members admitted with the targeted diagnoses will be approached to participate in the Molina Healthcare Transitions Program. Additional secondary criteria will be considered based on acuity and may include, but are not limited to, the following:

- Readmissions for targeted conditions for care management
- Alzheimer's disease
- Parkinson's disease

#### Transitions Program Features

During the Molina Healthcare Transitions Program, identified members receive standardized tools and learn self-management skills for ensuring their needs will be met when their conditions require that they receive care across multiple settings. The program has a high-touch, patient-centered focus with the Transitions Program staff conducting a face-to-face visit or telephone call during an inpatient hospitalization and a face-to-face visit or telephone call at the member's residence or secondary facility within 48 hours of discharge. Telephone calls are conducted to ensure the member is following the prepared plan, with phone calls taking place within seven, 14, and 30 days of member discharge.

Transitions Program staff function as facilitators of interdisciplinary collaboration across the transition, engaging the member and family caregivers to participate in the formation and implementation of an individualized care plan including interventions to mitigate the risk of re-hospitalization. The primary role of the Transitions Program staff is to encourage self-management and direct communication between the member and provider rather than to function as another health care provider.

Initial contact between the Transitions Program staff and member will be made during the inpatient stay. The Molina Healthcare Transitions Program staff will perform introductions, explain the program and describe the member's role within the program. The member may elect at this point not to participate in the program.

The Transitions Program staff will verify the provider, member address and telephone number, and provide the member with Molina Healthcare Transitions Program information, including contact information to access their Molina Healthcare representative. All members also receive the toll-free 24-Hour Nurse Advice Line phone number to call if they have questions or concerns after-hours.

The Transitions Program staff will use a tool to assess the member's risk of re-hospitalization and will assist in coordinating the discharge plan, which may include authorizing home care services or assisting the member with after-treatment and therapy services.

The face-to-face visit or telephone call at the member's residence or secondary facility are designed to provide continuity across the transition to empower members to actively engage in managing their care. During these visits/telephone calls, the Transitions Program staff expands upon the information provided in the initial



hospitalization contact and will assist the member with completion of his or her Personal Health Record, which includes his or her medication record. The Transitions Program staff will also conduct medication reconciliation. A review of red flags (i.e., warning symptoms or signs that the condition is worsening), education regarding the initial steps to manage these symptoms and when to contact their provider are discussed. The Transitions Program staff will assess the safety of the environment, the member's support network and community connections. The Transitions Program staff receives training in community resource referrals and will assist the member when needed with referrals for items such as food, transportation and clothing. The Interdisciplinary Care Team also includes a Social Worker to assist with community resources, if necessary. The Molina Healthcare Transitions Program fits within Molina Healthcare's Integrated Care Management Model, which promotes whole-person care. As the Transitions Program nears completion, Molina Healthcare's Transitions Program staff will identify any ongoing needs that a member may have and, if needed, communicate all relevant information to a designated Molina Healthcare Care Manager who will work with the member to address those needs going forward.

The inpatient and home visits/telephone calls will be conducted by Molina Healthcare staff or contracted designee. In the event that a contractor is used, the Molina Healthcare Transitions Program staff will provide oversight and document results in Clinical Care Advance, Molina Healthcare's Care Management software application. Documentation of all member transitions of care will occur in Clinical Care Advance, allowing for the capture of pertinent data for reporting purposes.

The table below outlines the triggers that will result in a member's placement into the Molina Healthcare Transitions Program and the possible interventions.

Triggers for Transitions Program	Interventions
Member exhibits any of the following: <ul style="list-style-type: none"> <li>• Asthma</li> <li>• Cellulitis</li> <li>• COPD</li> <li>• CHF</li> <li>• Diabetes</li> <li>• Pneumonia</li> <li>• Select behavioral health issues</li> <li>• Poly-pharmacy at the time of discharge</li> <li>• Multiple post-discharge therapies</li> </ul>	Multiple potential interventions up to 30 days post discharge, including: <ul style="list-style-type: none"> <li>• Support for medication self-management</li> <li>• Personal health record to facilitate communication and continuity across providers and settings</li> <li>• Follow-up to ensure member schedules and completes necessary visits with PCP and specialists</li> <li>• Member educated to recognize signs and symptoms that condition is worsening and how to respond</li> <li>• Follow-up appointment made to take place within seven days of discharge to reconnect with PCP/medical home and outpatient mental health as applicable</li> <li>• As needed on-site hospital pre-discharge visit</li> <li>• Post-discharge home visit or telephone call within 24 to 72 hours, as appropriate</li> <li>• Up to three follow-up telephone calls (seven, seven, 14 and 30 days post discharge)</li> </ul>

#### **N. Health Education and Disease Management Programs**

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

#### **O. Emergency Services**

Emergency services are covered on a 24-hour basis without the need for prior authorization for all members experiencing an emergency medical situation. Molina Healthcare accomplishes this service by providing Utilization Management during business hours and a 24-hour nurse triage option on the main telephone line for post-business hours. In addition, the 911 information is given to all members at the onset of any call to the plan.

For members within our service area, Molina Healthcare contracts with vendors that provide 24-hour emergency services for ambulance and hospitals. In the event that our member is outside of the service area, Molina Healthcare is prepared to authorize treatment to ensure that the patient is stabilized.

**P. Medical Record Standards**

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

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

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

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

At a minimum, each medical record must be legible and maintained in detail with the documentation outlined in the [Quality Improvement section](#) of this manual.

**Q. Medical Necessity Standards**

Medically necessary or medical necessity is defined as services that include medical or allied care, goods or services furnished or ordered that are:

- Necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain
- Individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs
- Consistent with the generally accepted professional medical standards as determined by applicable federal and state regulation, and not be experimental or investigational
- Reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide
- Furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider
- The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

**R. Specialty Pharmaceuticals/Injectable and Infusion Services**

Many self-administered and office-administered injectable products require PA. In some cases they will be made available through Molina Healthcare's vendor, Caremark Specialty Pharmacy. More information about our PA process, including a PA Request Form, is available in [PA section](#) of this manual.

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

## **VI. Credentialing**

The purpose of the Credentialing Program is to assure the Molina Healthcare network consists of quality providers who meet clearly defined criteria and standards.

The decision to accept or deny a credentialing applicant is based on primary source verification, recommendation of peer providers and additional information, as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law.

The Credentialing Program has been developed in accordance with state and federal requirements and accreditation guidelines. In accordance with those standards, Molina Healthcare members will not be referred and/or assigned to you until the credentialing process has been completed.

### **Criteria for Participation in the Molina Healthcare Network**

Molina Healthcare has established criteria and the sources used to verify these criteria for the evaluation and selection of providers for participation in the Molina Healthcare network. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Molina Healthcare network.

To remain eligible for participation, providers must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina Healthcare.

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

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

1. Provider must practice, or plan to practice within 90 calendar days, within the area served by Molina Healthcare.
2. All providers, including ancillary providers, (i.e. vision, pharmacy, etc.), must apply for enrollment in the Medicaid program. Providers are required to have a National Provider Identifier (NPI) or an Administrative Provider Identification Number (APIN).
3. Provider must complete and submit a credentialing application to Molina Healthcare. The application must be entirely complete. The provider must sign and date the application attesting it is complete and correct within 180 calendar days of the credentialing decision. If Molina Healthcare or the Credentialing Committee requests any additional information or clarification the provider must supply that information in the timeframe requested.
4. Provider must have a current, valid license to practice in their specialty in every state in which they will provide care for Molina Healthcare members.
5. If applicable to the specialty, provider must hold a current and unrestricted federal Drug Enforcement Agency (DEA) certificate and Controlled Substance Certification or Registration. If a provider has never had any disciplinary action taken related to his or her DEA or CDS and chooses not to have a DEA or CDS, the provider may be considered for network participation if he or she submits a written prescription plan describing the process for allowing another provider with a valid DEA or CDS certificate to write all prescriptions. If a provider does not have a DEA because of disciplinary action including, but not limited to, the DEA being revoked or relinquished, the provider is not eligible to participate in the Molina Healthcare network.
6. Providers will only be credentialed in an area of practice in which they have adequate education and training as outlined below. Therefore, providers must confine their practice to their credentialed area of practice when providing services to Molina Healthcare members.
7. Providers must have graduated from an accredited school with a degree required to practice in their specialty.
8. Oral surgeons and physicians (MDs, DOs) must have satisfactorily completed a training program from an accredited training program in the specialty in which they are practicing. Molina Healthcare only recognizes training programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada. Oral surgeons must have completed a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA).

9. Board certification in the specialty in which the provider is practicing is preferred, but not required. Initial applicants who are not Board Certified may be considered for participation only if they have satisfactorily completed a training program from an accredited training program in the specialty in which they are practicing. Molina Healthcare recognizes Board Certification only from the following Boards:
  - a. American Board of Medical Specialties (ABMS)
  - b. American Osteopathic Association (AOA)
  - c. American Board of Podiatric Surgery (ABPS)
  - d. American Board of Podiatric Medicine (ABPM)
  - e. American Board of Oral and Maxillofacial Surgery (ABOMS)
10. Providers who are not board-certified and have not completed a training program from an accredited training program are only eligible to be considered for participation as a general provider in the Molina Healthcare network. To be eligible, the provider must have maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history.
11. Provider must supply a minimum of five years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If the provider has practiced fewer than five years from the date of credentialing, the work history starts at the time of initial licensure. Experience practicing as a non-physician health professional (e.g. registered nurse, nurse practitioner, clinical social worker) within the five years should be included. If Molina Healthcare determines there is a gap in work history exceeding six months, the provider must clarify the gap either verbally or in writing. Verbal communication must be appropriately documented in the credentialing file. If Molina Healthcare determines there is a gap in work history that exceeds one year, the provider must clarify the gap in writing.
12. Provider must supply a full history of malpractice and professional liability claims and settlement history. This is requested from the provider on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the provider.
13. Provider must disclose a full history of all license actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Provider must also disclose any history of voluntarily relinquishing, withdrawing or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the provider.

14. At the time of initial application, the provider must not have any pending or open investigations from any state or governmental professional disciplinary body.<sup>1</sup> This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.
15. Provider must disclose all Medicare and Medicaid sanctions. Provider must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving federal contracts, certain subcontracts and certain federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the provider.
16. Provider must not be currently sanctioned, excluded, expelled or suspended from any state or federally funded program including but not limited to the Medicare or Medicaid programs.
17. Provider must have and maintain current professional malpractice liability coverage with limits that meet Molina Healthcare criteria. This coverage shall extend to Molina Healthcare members and the provider's activities on Molina Healthcare's behalf.
18. Provider must disclose any inability to perform essential functions of a provider in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the provider.
19. Provider must disclose if they are currently using any illegal drugs/substances. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the provider. If a provider discloses any issues with substance abuse (e.g. drugs, alcohol) the provider must provide evidence of either actively and successfully participating in a substance abuse monitoring program or successfully completing a program.
20. Provider must disclose if they have ever had any criminal convictions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the provider.
21. Provider must not have been convicted of a felony or pled guilty to a felony for a health care-related crime, including but not limited to, health care fraud, patient abuse and the unlawful manufacture distribution or dispensing of a controlled substance.
22. Provider must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the provider has had

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<sup>1</sup> If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

- privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the provider.
23. Physicians (MD, DO), primary care providers, nurse midwives, oral surgeons, podiatrists and/or those providers dictated by state law, must have admitting privileges in their specialty. If a provider chooses not to have admitting privileges, the provider may be considered for network participation if he or she has a plan for hospital admission by using a Hospital Inpatient Team or having an arrangement with a credentialed Molina Healthcare participating provider that has the ability to admit Molina Healthcare patients to a hospital. Providers practicing exclusively on a consultative basis are not required to have admitting hospital privileges. Physicians practicing in dermatology, occupational medicine, pain medicine, physical medicine and rehabilitation, psychiatry, sleep medicine, sports medicine, telemedicine, urgent care and wound management do not require admitting privileges.
  24. Providers not able to practice independently according to state law must have a practice plan with a supervising physician approved by the state licensing agency. The supervising physician must be contracted and credentialed with Molina Healthcare.
  25. Providers currently listed on the Medicare Opt-Out Report may not participate in the Molina Healthcare network for any Medicare line of business.
  26. If applicable to the specialty, provider must have a plan for shared call coverage that includes 24 hours a day, seven days a week and 365 days a year. The covering provider(s) must be qualified to assess over the phone if a patient should immediately seek medical attention or if the patient can wait to be seen on the next business day. All primary care providers must have 24 hour coverage. Physicians practicing in dermatology, occupational medicine, pain medicine, physical medicine and rehabilitation, sleep medicine, telemedicine, sports medicine, urgent care and wound management are not required to have 24-hour coverage.
  27. Molina Healthcare may determine, in its sole discretion, that a provider is not eligible to apply for network participation if the provider is an employee of a provider or an employee of a company owned in whole or in part by a provider who has been denied or terminated from network participation by Molina Healthcare, who is currently in the Fair Hearing Process, or who is under investigation by Molina Healthcare. Molina Healthcare also may determine, in its sole discretion, that a provider cannot continue network participation if the provider is an employee of such a provider or company. For purposes of these criteria, a company is “owned” by a provider when the provider has at least 5 percent financial interest in the company through shares or other means.
  28. Providers denied by the Credentialing Committee are not eligible to reapply until one year after the date of denial by the Credentialing Committee. At the time of reapplication, provider must meet all criteria for participation outlined above.
  29. Providers terminated by the Credentialing Committee or terminated from the network for cause are not eligible to reapply until five years after the date of



termination. At the time of reapplication, provider must meet all criteria for participation as outlined above.

30. Providers denied or terminated administratively are eligible to reapply for participation any time as long as the provider meets all criteria for participation above.

Molina Healthcare credentials the following types of practitioners:

- Audiologists
- Behavioral health care providers
- health care providers who are licensed, certified, or registered by the state to practice independently
- Doctors or masters level psychologists (Ed.D, Ph.D, Psy.D, Me.D)
- Masters level clinical social workers (MA, MSc, MSW)
  - Must be licensed to practice independently
- Masters level clinical nurse specialists (CNS)
  - Practicing independently in a practice in which there is no physician
- Chemical dependency counselors (LCDC)
  - Must be licensed to practice independently
- Licensed counselors (LPCC)
  - Must be licensed to practice independently
- Certified nurse midwives (CNM)
  - Only midwives who deliver
- Chiropractors (DC)
- Dentists (DDS and DMD)
- Dieticians (RD, DTR)
- Nurse practitioners (NP or CNP)
  - Practicing independently in a practice in which there is no physician
- Occupational therapists (OT)
- Practicing independent of a hospital
- Optometrists (OD)
- Oral surgeons (DDS/DMD)
- Podiatrists (DPM)
- Physicians (MD and DO)
- Physical therapists (PT)
- Practicing independent of a hospital
- Speech language pathologists (SLP)

Molina Healthcare credentials the following health delivery organizations:

- Ambulatory surgical centers
- Assisted living facilities
- Behavioral health facilities – inpatient
- Birthing centers
- Chemical dependency facilities – inpatient

- Dialysis centers
- Durable medical equipment (with professional services)
- Home Health care agencies
- Home IV therapy centers
- Hospice facilities
- Hospitals
- Independent diagnostic testing facilities
- Laboratories – freestanding or cardiac catheterization
  - Mental retardation & developmental disabilities (Ohio Department of Developmental Disabilities) facilities
- Outpatient clinics (if not covered by hospital accreditation)
- Pharmacies (with professional services)
- Radiology (Imaging) facilities – freestanding
- Rehabilitation centers – inpatient
- Skilled nursing facilities
- Urgent care centers

Providers who meet any of the following criteria do not need to be credentialed:

- Providers who practice exclusively within the inpatient setting and who provide care for members only as a result of the member being directed to the hospital or another inpatient setting
- Providers who practice exclusively within freestanding facilities and who provide care for organization members only as a result of being directed to the facility
- Providers who do not provide care for members in a treatment setting (board certified consultants)
- Covering providers (e.g., locum tenens who will be covering for less than 120 days)
- CNP/NPs who are in a practice in which there is a physician
- Nurse midwife who does not deliver
- DME providers who do not provide professional services
- Providers that are not licensed to practice independently

As an applicant, whether being credentialed or re-credentialed, providers are required to submit adequate information for a proper evaluation of:

- Experience
- Background
- Education and training
- Demonstrated ability and capability to perform as a provider without limitation, including physical and mental health status as allowed by law

Molina Healthcare contracts with some provider groups who have been delegated credentialing privileges. Prior to delegating this activity, Molina Healthcare conducts a thorough review of the group's credentialing and re-credentialing processes and

procedures, including reviews of files and credentialing committee minutes. For providers affiliated with a delegated provider group, the collection and verification of information is performed by the group and the provider names are submitted to the Molina Healthcare Peer Review Committee as described below for review.

Molina Healthcare does not make credentialing decisions based on an applicant's race, ethnic/national origin, gender, age, sexual orientation or the types of procedures or types of patients within the provider's discipline of care.

#### **A. The Credentialing Process**

Practitioners who are not a part of a provider group delegated for credentialing must follow the following steps before the provider can see Molina Healthcare members.

At the time of initial credentialing, the applicant must complete a state required Practitioner Application, which is the Council for Affordable Quality Healthcare (CAQH) credentialing application for physicians and the Ohio Department of Insurance Standard Credentialing Form for all other providers, plus all applicable attachments to the application. The correct application must be completed per the instructions on the front of the form. All practice sites must be provided (the entire form need not be duplicated for each site - submit only Section III: Office/Practice Information.)

#### **B. Burden of Proof**

The provider shall have the burden of producing adequate information to prove he or she meets all criteria for initial participation and continued participation in the Molina Healthcare network. This includes, but is not limited to, proper evaluation of the provider's experience, background, training, demonstrated ability and ability to perform without limitation, including physical and mental health status as allowed by law, and the burden of resolving any doubts about these or any other qualifications to participate in the Molina Healthcare network. If the provider fails to provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina Healthcare network. Providers who fail to provide this burden of proof do not have the right to submit an appeal.

#### **C. Credentialing Application**

At the time of initial credentialing and recredentialing, the provider must complete a credentialing application designed to provide Molina Healthcare with information necessary to perform a comprehensive review of the provider's credentials. The application must be completed in its entirety. The provider must attest that their application is complete and correct within 180 calendar days of the credentialing decision. The application must be completed in typewritten text, in pen or electronically through applications such as the Counsel for Affordable Quality Healthcare (CAQH) Universal Credentialing Data Source. Pencils or erasable ink will not be an acceptable writing instrument for completing credentialing applications. Molina Healthcare may use another organization's application as long as it meets all the factors. Molina Healthcare will accept faxed, digital, electronic, scanned or photocopied signatures. A signature

stamp is not acceptable on the attestation. The application must include, unless state law requires otherwise:

- Reason for any inability to perform the essential functions of the position, with or without accommodation
- Lack of present illegal drug use
- History of loss of license and felony convictions
- History of loss or limitation of privileges or disciplinary action
- Current malpractice insurance coverage
- Correctness and completeness of the application

#### **D. Inability to Perform Essential Functions and Illegal Drug Use**

An inquiry regarding illegal drug use and inability to perform essential functions may vary. Providers may use language other than “drug” to attest they are not presently using illegal substances. Molina Healthcare may accept more general or extensive language to query providers about impairments; language does not have to refer exclusively to the present or only to illegal substances.

#### **E. History of Actions Against Applicant**

An application must contain the following information, unless state law requires otherwise:

- History of loss of license
- History of felony convictions
- History of all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which a provider has had privileges;
- History of Medicare and Medicaid sanctions

#### **F. Current Malpractice Coverage**

The application form must include specific questions regarding the dates and amount of a provider's current malpractice insurance. Molina Healthcare may obtain a copy of the insurance face sheet from the malpractice carrier in lieu of collecting the information in the application.

For providers with federal tort coverage, the application does not need to contain the current amount of malpractice insurance coverage. Provider files that include a copy of the federal tort letter or an attestation from the provider of federal tort coverage are acceptable.

#### **G. Correctness and Completeness of the Application**

Providers must attest that their application is complete and correct when they apply for credentialing and recredentialing. If a copy of an application from an entity external to Molina Healthcare is used, it must include an attestation to the correctness and completeness of the application. Molina Healthcare does not consider the associated attestation elements as present if the provider did not attest to the application within the

required time frame of 180 days. If state regulations require Molina Healthcare to use a credentialing application that does not contain an attestation, Molina Healthcare must attach an addendum to the application for attestation.

#### **H. Meeting Application Time Limits**

If the provider attestation exceeds 180 days before the credentialing decision, the provider must attest that the information on the application remains correct and complete, but does not need to complete another application. It is preferred to send a copy of the completed application with the new attestation form when requesting the provider update the attestation.

#### **I. The Process for Making Credentialing Decisions**

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

Molina Healthcare recredentials its providers at least every 36 months. Approximately six months prior to the recredentialing due date, the providers application will be downloaded from CAQH (or a similar NCQA accepted online applications source), or a request will be sent to the provider requesting completion of a recredentialing application.

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

- Submit a completed application within the requested time frame.
- Attest to the application within the last 180 calendar days.
- Provide Molina Healthcare adequate information to prove he or she meets all criteria for initial participation or continued participation in the Molina Healthcare network.

Once the application is received, Molina Healthcare will complete all the verifications as outlined in the Molina Healthcare Credentialing Program Policy. In order for the application to be deemed complete, the provider must produce adequate information to prove he or she meets all criteria for initial participation or continued participation in the Molina Healthcare network. All fields within the application must be completed, all required attachments must be included, detailed explanations must be provided to all affirmative answers on the attestation questions and any additional information requested by Molina Healthcare must be provided.

If the provider does not provide the information necessary to complete the application process in the time period requested, the application will be deemed incomplete and Molina Healthcare will discontinue processing of the application. This will result in an administrative denial or administrative termination from the Molina Healthcare network.

Providers who fail to provide proof of meeting the criteria or fail to provide a complete credentialing application do not have the right to submit an appeal.

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

At each Credentialing Committee meeting, provider credentials files assigned a Level 2 are reviewed by the Credentialing Committee. All of the issues are presented to the Credentialing Committee members and open discussion of the issues commences. After the discussion, the Credentialing Committee votes for a final recommendation. The Credentialing Committee can approve, deny, terminate, approve on watch status, place on corrective action or defer their decision pending additional information.

1. The following documents must be submitted with:
  - Current, unrestricted license to practice
  - Current, valid Drug Enforcement Administration (DEA) certificate
  - Education and training locations and dates
  - Work history from the time of graduation
  - Board certification
  - Clinical admitting hospital privileges in good standing
  - Current, adequate malpractice liability coverage for all practice sites
  - All professional liability claims history
  - References
  - Evidence of 24-hour coverage
2. If a provider participates with the online CAQH process, the CAQH number must be submitted to Molina Healthcare, the online CAQH file must be current and the provider must indicate that Molina Healthcare has permission to access the application.
3. Upon receipt of the completed forms and all of the required documents, Molina Healthcare will query the National Practitioner Data Bank (NPDB)/Healthcare Integrity and Protection Data Bank (HIPDB) to verify education, work history, hospital privileges, board certification and malpractice history and coverage, and will also check for sanctions and other disciplinary actions.
4. If any of the forms are incomplete, or if any of the required documents are missing, the provider will be contacted and the corrected/required document will be requested.

5. After all information has been verified, either the Molina Healthcare Medical Director, Chief Medical Officer, or the Molina Healthcare Credentialing Committee reviews and approves all applicants prior to their contracts becoming effective.

The Credentialing Committee is made up of peer providers. The Governing Board of Molina Healthcare has delegated the authority to recommend approval or denial of applicants to the Credentialing Committee. The Credentialing Committee is required to meet no less than quarterly, but generally meets on a monthly basis to facilitate timely processing of applicant files.

Network providers may participate as a member of the Credentialing Committee. Interested individuals should contact the Molina Healthcare Medical Director at () (855) 322-4079.

### **Provider Termination and Reinstatement**

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

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

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

Providers credentialed by a delegate who terminate their contract with the delegate and either have an existing contract with Molina Healthcare or wish to contract with Molina Healthcare directly must be credentialed by Molina Healthcare within six months of the provider's termination with the delegate. If the provider has a break in service more than 30 calendar days, the provider must be initially credentialed prior to reinstatement.

### **Process for Delegating Credentialing and Recredentialing**

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

Molina Healthcare's Credentialing Committee retains the right to approve new providers and provider sites and terminate providers and sites of care based on requirements in the Molina Healthcare Credentialing Policy.

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

- Be National Committee for Quality Assurance (NCQA) accredited or certified for credentialing or pass Molina Healthcare's credentialing delegation pre-assessment, which is based on NCQA credentialing standards and requirements for the Medicaid and Medicare programs, with a score of at least 90 percent.
- Correct deficiencies within mutually agreed upon time frames when issues of non-compliance are identified by Molina Healthcare at pre-assessment.
- Agree to Molina Healthcare's contract terms and conditions for credentialing delegates.
- Submit timely and complete reports to Molina Healthcare as described in policy and procedure.
- Comply with all applicable Federal and State Laws.
- If the IPA or Provider Group subdelegates primary source verification to a Credentialing Verification Organization (CVO), the CVO must be NCQA certified in all 10 areas of accreditation.

### **Non-Discriminatory Credentialing and Recredentialing**

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

### **Notification of Discrepancies in Credentialing Information**

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



credentialing verification requirements or if disclosure is prohibited by law. Please also refer to the section below titled Providers Right to Correct Erroneous Information.

### **Notification of Credentialing Decisions**

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

### **Confidentiality and Immunity**

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

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

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

By providing patient care services at Molina Healthcare, a provider:

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

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

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

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

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

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

**Cumulative Effect:** The provisions in this policy and procedure and any forms relating to authorizations, confidentiality of information and immunities from liability are in addition to other protections provided by relevant state and federal law, and are not a limitation thereof.

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

The Director in charge of Credentialing grants access to electronic credentials files only as necessary to complete credentialing work or as required by law. Access to these documents are restricted to authorized staff, Credentialing Committee members, peer reviewers and reporting bodies as authorized by the Credentialing Committee or the Governing Board of Molina Healthcare. Each person is given a unique user ID and

password. It is the strict policy of Molina Healthcare that employees keep their passwords confidential and never share their passwords with anyone. All Credentialing employees are prompted to change their passwords into the system every three months.

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

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

### **Providers' Rights during the Credentialing Process**

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

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

The only items in the file that may be copied by the provider are documents which the provider sent to Molina Healthcare (e.g., the application, the license and a copy of the DEA certificate). Providers may not copy documents that include pieces of information that are confidential in nature, such as the provider credentialing checklist, the responses from monitoring organizations (i.e. National Practitioner Data Bank, State Licensing Board) and verification of hospital privileges letters.

### **Providers' Rights to Correct Erroneous Information**

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

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

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

- Their requirement to submit a written response within 10 calendar days of receiving notification from Molina Healthcare.
- In their response, the provider must explain the discrepancy, may correct any erroneous information and may provide any proof that is available.
- The provider's response must be sent to:

Molina Healthcare  
Attention: CPCS, Credentialing Director  
P.O. Box 2470  
Spokane WA 99210

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

If the provider does not respond within 10 calendar days, the application processing will be discontinued and network participation will be denied.

### **Providers' Rights to be Informed of Application Status**

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

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

### **Credentialing Committee**

Molina Healthcare designates a Credentialing Committee to make recommendations regarding credentialing decisions using a peer review process. Molina Healthcare works with the Credentialing Committee to assure that network providers are competent and qualified to provide continuous quality care to Molina Healthcare members. A provider

may not provide care to Molina Healthcare members until the credentialing process is complete and the final decision has been rendered.

The Credentialing Committee is responsible for reviewing and evaluating the qualifications of applicant providers and making recommendations regarding their participation in the Molina Healthcare network. In addition, the Credentialing Committee reviews Credentialing policies and procedures annually and recommends revisions, additions and/or deletions to the policies and procedures. Composed of network providers, the committee is responsible for performing peer review of medical information when requested by the Medical Director, and recommending actions based on peer review findings, if needed. The committees report to the Quality Improvement Committee (QIC).

Each Credentialing Committee member shall be immune, to the fullest extent provided by law, from liability to an applicant or provider for damages or other relief for any action taken or statements or recommendations made within the scope of the committee duties exercised.

### **Committee Composition**

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

- Family medicine
- Internal medicine
- Pediatrics
- OB/GYN
- Surgery

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

### **Committee Members Roles and Responsibilities**

- Committee members participate in and support the functions of the Credentialing Committee by attending meetings, providing input and feedback and overall guidance of the Credentialing Program.
- Review/approve credentialing program policy and related policies established by Molina Healthcare on an annual basis, or more often as deemed necessary.

- Review and consider each applicant's information based on criteria and compliance requirements. The Credentialing Committee votes to make final recommendations regarding applicant's participation in the Molina Healthcare network.
- Conduct ongoing monitoring of those providers approved to be monitored on a "watch status."
- Access clinical peer input when discussing standards of care for a particular type of provider when there is no committee member of that specialty.
- Ensure credentialing activities are conducted in accordance with Molina Healthcare's Credentialing Program.
- Review Quality Improvement findings as part of the recredentialing and the ongoing monitoring process.

### **Excluded Providers**

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

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

### **Ongoing Monitoring of Sanctions**

Molina Healthcare monitors provider sanctions between recredentialing cycles for all provider types and takes appropriate action against providers when occurrences of poor quality are identified.

### **Medicare Opt-Out**

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

### **Medicare and Medicaid Sanctions**

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

Every month, Molina Healthcare also monitors for state Medicaid sanctions/exclusions/terminations through each state's specific Program Integrity Unit (or equivalent). If a Molina Healthcare provider is found to be sanctioned/excluded/terminated from any state's Medicaid program, the provider will be terminated in every state where they are contracted with Molina Healthcare and for every line of business.

### **Sanctions or Limitations on Licensure**

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

### **NPDB Continuous Query (Proactive Disclosure Service)**

Molina Healthcare enrolls all network providers with the National Practitioner Data Bank ("NPDB") Continuous Query service.

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

### **Member Complaints/Grievances**

Each Molina Healthcare health plan has a process in place to investigate provider-specific complaints from members upon their receipt. Molina Healthcare evaluates both the specific complaint and the provider's history of issues, if applicable. The history of complaints is evaluated for all providers at least every six months.

### **Adverse Events**

Each Molina Healthcare health plan has a process in place for monitoring provider adverse events at least every six months. An adverse event is an injury that occurs while a member is receiving health care services from a provider. Molina Healthcare monitors for adverse events at least every six months.

### **System for Award Management (SAM)**

Molina Healthcare monitors the SAM once per month to ensure providers have not been sanctioned. If a Molina Healthcare provider is found with a sanction, the provider's contract is terminated effective the same date the sanction was implemented.

### **Medicare Opt-Out**

Providers participating in Medicare must not be listed on the Medicare opt-out report. Molina Healthcare reviews the opt-out reports released from the appropriate Medicare financial intermediary showing all of the providers who have chosen to opt-out of Medicare. These reports are reviewed within 30 calendar days of their release. If a physician or other provider opts out of Medicare, that physician or provider may not accept federal reimbursement for a period of two years. These provider contracts will be immediately terminated for the Molina Healthcare Medicare line of business.

### **Program Integrity (Disclosure of Ownership/Controlling Interest)**

Medicaid managed care plans are required to collect specific information from network providers prior to contracting and during credentialing to ensure that it complies with federal regulations that require monitoring of federal and state sanctions and exclusions databases. This monitoring ensures that any network providers and the following details of any individual/entity being contracted and those individuals/entities affiliated with the contractor are appropriately screened against these sources, ensuring compliance with 42 CFR §455. The categorical details required and collected at all initial and recredentialing must be current and as follows:

1. Detailed identifying information for any individual who has ownership or controlling interest in the individual/entity being contracted if that individual has a history of criminal activity related to Medicaid, Medicare, or Title XX services (see 42 CFR §455.106).
2. Detailed identifying information for all individuals who exercise operational or managerial control either directly or indirectly over daily operations and activities (see 42 CFR §455.101).
3. Detailed identifying information for all individuals or entities that have a 5% or more ownership or controlling interest in the individual/entity being contracted (see 42 CFR §455.104).

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

A review of office sites where you see Molina Healthcare members may be required. This review may be scheduled as soon as the Credentialing department receives your application. This may also include a review of your medical record keeping practices. A passing score is required to complete the application process. Your cooperation in



working with the site review staff and implementing any corrective action plans will expedite a credentialing decision.

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

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

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

### **Range of Actions Available**

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

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

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

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

The criteria used by the Credentialing Committee to make a decision to deny or terminate a provider from the Molina Healthcare network include, but are not limited to, the following:

1. The provider's professional license in any state has or has ever had any informal or formal disciplinary orders, decisions, agreements, disciplinary actions or other actions including, but not limited to, restrictions, probations, limitations, conditions, suspensions, and revocations.
2. Provider has or has ever surrendered, voluntarily or involuntarily, his or her professional license in any state while under investigation by the state or due to findings by the state resulting from the provider's acts, omissions or conduct.

3. Provider has any pending statement of charges, notice of proposed disciplinary actions, notice of agency action or the equivalent from any state or governmental professional disciplinary body which based on the judgment of the Credentialing Committee establishes an immediate potential risk to the quality of care or service delivered by the provider to Molina Healthcare members.
4. Provider has or has ever had any restrictions, probations, limitations, conditions, suspensions or revocations on their federal Drug Enforcement Agency (DEA) certificate or Controlled Substance Certification or Registration.
5. Provider has a condition, restriction or limitation on their license, certification or registration related to an alcohol, chemical dependency, or health condition or if other evidence indicates that the provider has an alcohol, chemical dependency problem or health condition and there is no clear evidence and documentation demonstrating that the provider has complied with all such conditions, limitations, or restrictions and is receiving treatment adequate to ensure that the alcohol, chemical dependency problem or health condition will not affect the quality of the provider's practice.
6. Provider has or has ever had sanctions of any nature taken by any Governmental Program or professional body including but not limited to, Medicare, Medicaid, Federal Employee Program or any other state or federal program or agency.
7. Provider has or has ever had any denials, limitations, suspensions or terminations of participation of privileges by any health care institution, plan, facility or clinic.
8. Provider's history of medical malpractice claims or professional liability claims or settlements reflect what constitutes a pattern of questionable or inadequate treatment or contain what constitutes any gross or flagrant incident or incidents of malpractice.
9. Provider has a criminal history, including, but not limited to, any criminal charges, criminal investigations, convictions, no-contest pleas and guilty pleas.
10. Provider has or has ever had involvement in acts of dishonesty, fraud, deceit or misrepresentation that relate to or impact or could relate to or impact the provider's professional conduct or the health, safety or welfare of Molina Healthcare members.
11. Provider has or has ever engaged in acts which Molina Healthcare, in its sole discretion, deems inappropriate.
12. Provider has or has ever had a pattern of member complaints or grievances in which there appears to be a concern regarding the quality of service provided to Molina Healthcare members.
13. Provider has not complied with Molina Healthcare's quality assurance program.
14. Provider is found to have rendered a pattern of substandard care or is responsible for any gross or flagrant incident of substandard care.
15. Provider has or has ever displayed inappropriate patterns of referral, which deviate substantially from reasonably expected patterns of referral.
16. Provider makes or has ever made any material misstatements in or omissions from their credentialing application and attachments.
17. Provider has ever rendered services outside the scope of their license.

18. Provider has or has ever had a physical or mental health condition that may impair their ability to practice with the full scope of licensure and qualifications, or might pose a risk of harm on patients.
19. Provider has or has ever failed to comply with the Molina Healthcare Medical Record Review Guidelines.
20. Provider has or has ever failed to comply with the Molina Healthcare Site Review or Medical Record Keeping Practice Review Guidelines.

### **Monitoring on a Committee Watch Status**

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

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

### **Corrective Action**

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

A corrective action plan is a written improvement plan, which may include, but is not limited to, the following:

- Identifying the performance issues that do not meet expectations
- What actions/processes will be implemented for correction
- Who is responsible for the corrective action
- What improvement/resolution is expected
- How improvements will be assessed
- Scheduled follow-up, monitoring (compliance review, normally not to exceed six months)

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

- The reason for the corrective action
- The corrective action plan

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

### **Summary Suspension**

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

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

- A description of the action being taken
- Effective date of the action
- The reason(s) for the action and/or information being investigated
- Information (if any) required from the provider
- The length of the suspension
- The estimated timeline for determining whether or not to reinstate or terminate the provider
- Details regarding the provider's right to request a fair hearing within 30 calendar days of receipt of the notice and their right to be represented by an attorney or another person of their choice (see Fair Hearing Plan policy)
- If the provider does not request a fair hearing within the 30 calendar days, he or she has waived his or her rights to a hearing
- The action will be reported to the National Practitioner Data Bank (NPDB) if the suspension is in place longer than 30 calendar days

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

### **Denial**

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

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

### **Termination**

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

### **Terminations for Reasons Other Than Unprofessional Conduct or Quality of Care**

If the termination is based on reasons other than unprofessional conduct or quality of care, the provider will not be reported to the NPDB and will not be given the right to a fair hearing. Within 10 calendar days of the Committee's decision, the provider is sent a written notice of termination via certified mail, from the Medical Director, which includes the following:

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

### **Terminations Based on Unprofessional Conduct or Quality of Care**

If the termination is based on unprofessional conduct or quality of care, the provider will be given the right to a fair hearing.

Within 10 calendar days of the Committee's decision, the provider is sent a written notice of Molina Healthcare's intent to terminate them from the network, via certified mail from the Medical Director, which includes the following:

- Description of the action being taken.
- Reason for termination.
- Details regarding the provider's right to request a fair hearing within 30 calendar days of receipt of notice (see Fair Hearing Plan policy). The Fair Hearing Policy explains that Molina Healthcare will appoint a hearing officer and a panel of individuals to review the appeal.
- Notice that if the provider does not request a fair hearing within the 30 calendar days, he or she has waived his or her rights to a hearing.
- Copy of the Fair Hearing Plan Policy describing the process in detail.
- Provider's right to be represented by an attorney or another person of their choice.
- Obligations of the provider regarding further care of Molina Healthcare members.
- The action will be reported to the NPDB and the State Licensing Board.

Molina Healthcare will wait 30 calendar days from the date the terminated provider received the notice of termination. If the provider requests a fair hearing within that required time frame, Molina Healthcare will follow the Fair Hearing Plan Policy. Once the hearing process is completed, the provider will receive written notification of the

appeal decision, which will contain specific reasons for the decision (see Fair Hearing Plan Policy). If the hearing committee's decision is to uphold the termination, the action will be reported to the State Licensing Board and the NPDB as defined in reporting to appropriate authorities section below. If the hearing committee overturns the termination decision and the provider remains in the Molina Healthcare network, the action will not be reportable to the State Licensing Board or to the NPDB.

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

### **Reporting to Appropriate Authorities**

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

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

Within 15 calendar days of the effective date of the final action, the manager responsible for credentialing reports the action to the following authorities:

- All appropriate state licensing agencies.
- NPDB.

A letter is then written to the appropriate state licensing boards describing the adverse action taken, the provider it was taken against and a copy of the NPDB report is attached to the letter. This letter is sent certified to the appropriate state licensing boards within 24 hours of receiving the final NPDB report. A copy of this letter is filed into the provider's credentials file. The action is also reported to other applicable state entities as required.

### **Fair Hearing Plan Policy**

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

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

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**A. Definitions**

- a. Adverse Action shall mean an action that entitles a provider to a hearing, as set forth in Section B (1)-(3) below.
- b. Chief Medical Officer shall mean the Chief Medical Officer for the respective Molina Healthcare Affiliate state plan wherein the provider is contracted.
- c. Days shall mean calendar days. In computing any period of time prescribed or allowed by this policy, the day of the act or event from which the designated period of time begins shall not be included.
- d. Medical Director shall mean the Medical Director for the respective Molina Healthcare Affiliate state plan wherein the provider is contracted.
- e. Molina Healthcare shall mean the respective Molina Healthcare Affiliate state plan wherein the provider is contracted.
- f. Notice shall mean written notification sent by certified mail, return receipt requested or personal delivery.
- g. Peer Review Committee or Credentialing Committee shall mean a Molina Healthcare plan committee or the designee of such a committee.
- h. Plan President shall mean the Plan President for the respective Molina Healthcare Affiliate state plan wherein the provider is contracted.
- i. Provider shall mean physicians, dentists and other health care practitioners as defined by 42 USC 11151 and Social Security Act § 1861(u).
- j. State shall mean the licensing board in the state in which the provider practices.
- k. State Licensing Board shall mean the state agency responsible for the licensure of provider.
- l. Unprofessional Conduct refers to a basis for corrective action or termination involving an aspect of a provider's competence or professional conduct which is reasonably likely to be detrimental

to patient safety or the delivery of quality care. Unprofessional conduct does not refer to instances where a provider violates a material term of the provider's contract with a Molina Healthcare plan.

**B. Grounds for a Hearing**

Grounds for a hearing exist whenever the Peer Review Committee or Credentialing Committee takes or recommends any of the following Adverse Actions for a provider based upon unprofessional conduct:

1. Revocation, termination of or expulsion from Molina Healthcare provider status when such revocation, termination or expulsion is reportable to the State Licensing Board and the NPDB.
2. Suspension, reduction, limitation or revocation of authority to provide care to Molina Healthcare members when such suspension, reduction, limitation or revocation is reportable to the State Licensing Board and the NPDB.
3. Any other final action by Molina Healthcare that by its nature is reportable to the State Licensing Board and the NPDB.

**C. Notice of Action**

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

1. State the reasons for the action.
2. State any Credentialing Policy provisions that have been violated.
3. Advise the provider that he or she has the right to request a hearing on the proposed Adverse Action.
4. Advise the provider that any request for hearing must be made in writing within 30 days following receipt of the Notice of Action, and must be sent to the respective Molina Healthcare Plan Medical Director by certified mail, return receipt requested or personal delivery.
5. Advise the provider that he or she has the right to be represented by an attorney or another person of their choice
6. Advise the provider that the request for a hearing *must* be accompanied by a check in the amount of \$1,000.00 as a deposit for the administrative expenses of the hearing and specify that this amount will be refunded if the Adverse Action is overturned.
7. State that the proposed action or recommendation, if adopted, must be reported pursuant to state and federal law.
8. Provide a summary of the provider's hearing rights or attach a copy of this policy.

**D. Request for a Hearing - Waiver**

If the provider does not request a hearing in writing to the Chief Medical Officer within 30 days following receipt of the Notice of Action, the provider shall be deemed to have accepted the action or recommendation of the Peer Review Committee and/or



Credentialing Committee, and such action or recommendation shall be submitted to the Chief Medical Officer for final decision. In the event that a timely written Request for Hearing is received, a Hearing Officer and/or hearing panel shall be appointed as set forth below and the Peer Review Committee and/or Credentialing Committee shall provide the provider with a Notice of Hearing and Statement of Charges consistent with this policy.

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

E. Appointment of a Hearing Committee

1. Composition of Hearing Committee

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

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

2. Scope of Authority

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

3. Responsibilities

The Hearing Committee shall:

- (i) Evaluate evidence and testimony presented.
- (ii) Issue a decision accepting, rejecting or modifying the decision of the Peer Review Committee and/or Credentialing Committee.

(iii) Maintain the privacy of the hearing unless the law provides to the contrary.

4. Vacancies

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

5. Disclosure and Challenge Procedures

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

6. Hearing Officer

a. Election

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

b. Scope of Authority

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

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

c. Responsibilities

The Hearing Officer shall:

- i. Guide the hearing process, including endeavoring to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner;. Ensure that proper decorum is maintained.
- ii. Be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing.

- iii. Issue rulings pertaining to matters of law, procedure and the admissibility of evidence.
- iv. Issue rulings on any objections or evidentiary matters.
- v. Discretion to limit the amount of time.
- vi. Assure that each witness is sworn in by the court reporter.
- vii. May ask questions of the witnesses (but must remain neutral/impartial).
- viii. May meet in private with the panel members to discuss the conduct of the hearing.
- ix. Remind all witnesses at the conclusion of their testimony of the confidentiality of the hearing.
- x. Participate in the deliberations of the Hearing Committee as a legal advisor, but shall not be entitled to vote.
- xi. Prepare the written report.

#### 7. Time and Place of Hearing

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

#### 8. Notice of Hearing

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

- a. The date, time and location of the hearing.
- b. The name of the Hearing Officer.
- c. The names of the Hearing Committee members.
- d. A concise statement of the affected provider's alleged acts or omissions giving rise to the Adverse Action or recommendation, and any other reasons or subject matter forming the basis for the Adverse Action or recommendation, which is the subject of the hearing.
- e. The names of witnesses, so far as they are then reasonably known or anticipated, who are expected to testify on behalf of the Peer Review Committee and/or Credentialing Committee, provided the list may be updated as necessary and appropriate, but not later than 10 days prior to the commencement of the hearing.
- f. A list of all documentary evidence forming the basis of the charges reasonably necessary to enable the provider to prepare a defense,

including all documentary evidence, which was considered by the Peer Review Committee and/or Credentialing Committee in recommending the Adverse Action.

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

9. Pre-Hearing Procedures

- a. The provider shall have the following pre-hearing rights:
  - i. To inspect and copy, at the provider's expense, documents upon which the charges are based which the Peer Review Committee and/or Credentialing Committee have in its possession or under its control; and
  - ii. To receive, at least 30 days prior to the hearing, a copy of the evidence forming the basis of the charges, which is reasonably necessary to enable the provider to prepare a defense, including all evidence that was considered by the Peer Review Committee and/or Credentialing Committee in recommending Adverse Action.
- b. The Hearing Committee shall have the following pre-hearing right:
  - i. To inspect and copy, at Molina Healthcare's expense, any documents or other evidence relevant to the charges, which the provider has in his or her possession or control as soon as practicable after receiving the hearing request.
- c. The Hearing Officer shall consider and rule upon any request for access to information and may impose any safeguards required to protect the peer review process, privileges and ensure justice. In so doing, the Hearing Officer shall consider:
  - i. Whether the information sought may be introduced to support or defend the charges;
  - ii. The exculpatory or inculpatory nature of the information sought, if any;
  - iii. The burden attendant upon the party in possession of the information sought if access is granted; and
  - iv. Any previous requests for access to information submitted or resisted by the parties.
- d. The provider shall be entitled to a reasonable opportunity to question and object to or challenge the impartiality of members of the Hearing Committee and the Hearing Officer. Challenges to the impartiality of any Hearing Committee member or the Hearing Officer shall be ruled on by the Hearing Officer.

- e. It shall be the duty of the provider, the Peer Review Committee and/or Credentialing Committee to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.
- f. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least 10 days before the commencement of the hearing shall constitute good cause for a continuance or limitation of the evidence or the testimony if deemed appropriate by the Hearing Officer.
- g. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable physicians or patients, other than the provider under review, or to information, interviews, reports, statements, findings and conclusions resulting from studies or other data prepared specifically to be submitted for review purposes made privileged by operation of state.

10. Conduct of Hearing

a. Rights of the Parties

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

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

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

b. Course of the Hearing

- i. Each party may make an oral opening statement.
- ii. The Peer Review Committee and/or Credentialing Committee shall call any witnesses and present relevant documentary evidence to support its recommendation.
- iii. The affected provider may then call any witnesses and present relevant documentary evidence supporting his or her defense.

- iv. The Hearing Committee or Officer has the discretion to vary the course of the hearing, but shall afford a full and equal opportunity to all parties for the presentation of material and relevant evidence and for the calling of witnesses.
  - v. The Hearing Committee shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence shall not be necessary. All evidence shall be taken in the presence of the entire Hearing Committee and all of the parties, except when agreed to by the parties, or determined by the Hearing Officer.
- c. Use of Exhibits
- i. Exhibits, when offered by either party, may be received into evidence by the Hearing Committee as ruled upon by the Hearing Officer.
  - ii. A description of the exhibits in the order received shall be made a part of the record.
- d. Witnesses
- i. Witnesses for each party shall submit to questions or other examination.
  - ii. The Hearing Officer shall have the power to sequester witnesses (exclude any witness, other than a party or other essential person, during the testimony of any other witness). The names and addresses of all witnesses and a description of their testimony in the order received shall be made a part of the record.
  - iii. The Hearing Committee may receive and consider the evidence of witnesses by affidavit, but shall give it only such weight as the Hearing Committee deems it is entitled to after consideration of any objection made to its admission.
  - iv. The party producing such witnesses shall pay the expenses of their witnesses.
- e. Rules for Hearing:
- i. Attendance at Hearings  
Only those persons having a direct interest in the hearing are entitled to attend the hearing. This means that the hearing will be closed except for the parties and their representatives. The only exception is when good cause is shown satisfactory to the Hearing Officer that it is necessary in the interest and fairness of the hearing to have others present.

ii. Communication with Hearing Committee

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

iii. Interpreter

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

f. Close of the Hearing

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

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

- i. A summary of facts and circumstances giving rise to the hearing.
- ii. A description of the hearing, including:
  - The panel members' names and specialties;
  - The Hearing Officer's name;
  - The date of the hearing;
  - The charges at issue; and
  - An overview of witnesses heard and evidence.
- iii. The findings and recommendations of the Hearing Committee.
- iv. Any dissenting opinions desired to be expressed by the hearing panel members.

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

11. Burden of Proof

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

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

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

12. Provider Failure to Appear or Proceed

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

13. Record of the Hearing/Oath

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

14. Representation

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

15. Postponements

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

16. Notification of Finding

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

17. Final Decision

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



#### 18. Reporting

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

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

#### 19. Exhaustion of Internal Remedies

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

#### 20. Confidentiality and Immunity

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

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

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

By providing patient care services at Molina Healthcare, a provider:

- a. Authorizes representatives of Molina Healthcare to solicit, provide and act upon information bearing on the provider’s qualifications.
- b. Agrees to be bound by the provisions of this policy and procedure and to waive all legal claims against any representative who acts in accordance with the provisions of this policy and procedure.
- c. Acknowledges that the provisions of this policy and procedure are express conditions of the application for, or acceptance of, Molina Healthcare membership and the continuation of such membership,

and to the exercise of clinical privileges or provision of patient care.

The confidentiality and immunity provisions of this policy and procedure shall apply to all information so protected by state or federal law. To the fullest extent permitted by state or federal law, the confidentiality and immunity provisions of this policy and procedure shall include, but are not limited to:

- a. Any type of application or reapplication received by the provider;
- b. Actions reducing, suspending, terminating or revoking a provider's status, including requests for corrective actions, investigation reports and documents and all other information related to such action;
- c. Hearing and appellate review;
- d. Peer review and utilization and quality management activities;
- e. Risk management activities and claims review;
- f. Potential or actual liability exposure issues;
- g. Incident and/or investigative reports;
- h. Claims review;
- i. Minutes of all meetings by any committees otherwise appropriately appointed by the Board;
- j. Any activities related to monitoring the quality, appropriateness or safety of health care services;
- k. Minutes of any Committees and Subcommittees related to monitoring the quality, appropriateness or safety of health care services;
- l. Any Molina Healthcare operations and actions relating to provider conduct.

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

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

**Cumulative Effect:** The provisions in this policy and procedure and any forms relating to authorizations, confidentiality of information and immunities from liability are in addition to other protections provided by relevant state and federal law, and are not a limitation thereof.

## 21. Provider Appeal Rights

In cases where the Credentialing Committee suspends or terminates a provider's contract based on professional conduct, a certified letter is sent to the provider describing the Adverse Action taken and the reason for the action, including notification to the provider of the right to a fair hearing, when required pursuant to laws or regulations.

## VII. Quality Improvement

### A. Introduction

Molina Healthcare established a Quality Improvement Program (QIP) to provide the structure and key processes to enable the plan to carry out its commitment to ongoing improvement of care, service and the health of its membership. The QIP is an evolving program that is responsive to the changing needs of the health plan membership and the standards established by the medical community, regulators and accrediting bodies.

The Quality Improvement section of the Provider Manual contains a summary of the Molina Healthcare QIP. For a complete written copy of Molina Healthcare's QIP, you can contact your Provider Services Representative or call (855) 322-4079.

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

- 1. Development of quality improvement activities*
- 2. Public reporting to consumers*
- 3. Preferred status designation in the network*
- 4. Reduced member cost sharing.*

### B. Improving the health status of health plan membership

In order to help improve the health status of members, Molina Healthcare has implemented several preventive health programs, including:

- Member and provider incentive programs to increase the utilization of preventive health services
- Postcard reminders regarding recommended preventive health services
- Reminder calls to members regarding recommended preventive health services
- Missed service alert system which reminds members of missed preventive services at contact points with members
- Preventive health guidelines available to members and providers
- Educational articles on preventive services in member and provider communications

Molina Healthcare also participates in state-mandated Performance Improvement Projects (PIPs), which include several additional initiatives to improve health status for specific members based on the PIP. Currently, Molina Healthcare participates in transition of care, newborn intensive care unit (ICU), and postpartum PIPs.

Molina Healthcare has Disease Management programs for members with chronic conditions, including:

- Asthma and COPD
- Hypertension, coronary artery disease and CHF
- Diabetes

Molina Healthcare encourages members who have special and/or complex health needs to enroll in medical Care Management as well. Practitioners/providers may refer members to be included in a Disease Management or Care Management program by calling (866) 774-1510.

Molina Healthcare has an internal integrated comprehensive care management team for medical and behavioral health care services to ensure the best overall health care management for members. If you have any questions regarding Care Management or behavioral health Care Management, you may contact your Provider Relations Representative or call Provider Services at (855) 322-4079.

#### **C. Ensuring the quality of care and service provided to members**

It is Molina Healthcare's policy to review and resolve potential quality of care and quality of service issues in cooperation with involved providers. Appropriate Quality Improvement personnel (RNs for clinical issues) investigate all potential quality of care issues referred to the QI department, document the results of the review, track issues with similar outcomes, and report individual cases or systematic trends to the Quality Improvement Committee for review by appropriate physicians.

#### **D. Identifying and implementing appropriate safety and error avoidance initiatives**

Molina Healthcare promotes medical safety and error avoidance for members and providers by implementing initiatives designed to educate practitioners/providers and members regarding safety and error avoidance. Some initiatives we have implemented include:

- Publication of safety-related articles in member and provider communications
- Distribution of safe office practice standards to providers
- Clinical office site assessments

#### **E. Improving the coordination and continuity of member health care**

- Molina Healthcare investigates and resolves all potential quality of care issues specific to coordination of care, involving appropriate practitioners and providers as needed.
- A focused medical record audit for evidence of coordination of care is conducted annually, and deficient offices may receive a Corrective Action Plan (CAP) request based on this review. In order to ensure continuity and coordination of care, a follow-up review of medical records will be conducted for offices that have been issued CAPs.

- Molina Healthcare conducts a Provider Satisfaction Survey including assessment of providers' satisfaction with coordination of care between settings.
- Molina Healthcare promotes enhanced communication between primary care providers (PCPs) and specialty care practitioners by requiring specialty care practitioners to provide treatment notes to the PCP.
- Molina Healthcare conducts the Consumer Assessment of Health Plan Survey (CAHPS<sup>®</sup>) to improve member satisfaction.

#### **F. Evaluating the access and availability of care and service**

Molina Healthcare is committed to timely access to care for all members in a safe and healthy environment. Practitioners/providers are required to conform to the Access to Care appointment standards listed in the table below to ensure that health care services are provided in a timely manner. Molina Healthcare assesses practitioners and providers against these standards as follows:

- Comprehensive annual network analyses for access to primary, specialty and ancillary care
- Monthly review of member access grievances
- Annual provider appointment and after hours availability surveys
- Continuous monitoring of Member Services call statistics to ensure results are within standards. For a complete list of standards please refer to the [Provider Responsibilities section](#) of this manual.

#### **G. Women's Open Access**

Molina Healthcare allows members the option to seek obstetrical and gynecological care from an obstetrician or gynecologist or directly from a participating PCP designated by Molina Healthcare as providing obstetrical and gynecological services. Ongoing grievance analysis is performed in order to identify any trends or opportunities for improvement, including member access to obstetrical and gynecological services.

#### **H. Ensuring that medical records comply with standards of structural integrity and contain evidence of appropriate medical practices for quality care**

Molina Healthcare requires that medical records are maintained in a manner that is current, detailed, and organized to ensure that care rendered to members is consistently documented and that necessary information is readily available in the medical record. Molina Healthcare conducts random audits of medical records to ensure compliance with the following standards.

- Practitioner medical record keeping practices must demonstrate an overall 80 percent compliance with the Medical Record Keeping Practice Guidelines listed below.
- If a serious deficiency is noted during the review, but the office demonstrates overall compliance, a follow-up review may be required at the discretion of the Site Reviewer to ensure correction of the deficiency.

- A review score below 80 percent will result in a request for a CAP from deficient offices. The due date for the CAP is included in the letter to the provider office, and a follow-up site visit to ensure deficiencies are corrected will occur within six months from the due date of the CAP.

**Content**

- Patient name or ID number is on all pages
- Date of birth, sex, emergency contact and legal guardianship (if applicable)
- Biographical data is maintained in medical record or database
- Medication allergies/adverse reactions are prominently noted. If no known allergies/adverse reactions, also prominently noted
- Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations, and illnesses. For children/adolescents (age 18 and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses
- Chief complaint/diagnosis/impressions including behavioral health
- Significant illnesses and medical conditions are indicated on problem list
- Treatment plans are consistent with diagnosis
- Therapies administered/prescriptions with dosage and dates of initial and refills
- Working diagnoses are consistent with findings
- Recommendations and instructions to enrollee, follow-up, and outcomes
- Preventive health measures (i.e. immunizations, pap, etc.) addressed
- A system is in place to document telephone contacts
- History of tobacco products and alcohol/substance abuse
- History of emergency/hospital services with appropriate follow-up
- All entries are signed and dated
- No evidence patient is placed at inappropriate risk by a diagnosis or therapeutic procedure
- Unresolved problems from previous office visits are addressed in subsequent visits
- Evidence of member's Advance Directives (if applicable)
- If a consultant is requested, there is a note from the consultant
- Documentation of primary care services is present in the medical record
- Documentation of all ancillary services/diagnostic tests ordered
- Documentation of referrals for all diagnostic and therapeutic services

**Information Filed**

- Results of referrals/studies ordered (i.e. lab, x-ray, EKG)
- Results of consultations, therapy, lab or ancillary service reports or notation is made at subsequent visit, and are initialed by the ordering practitioner to signify review
- If provider admitted patient to the hospital in the past 12 months for more than 48 hours, a discharge summary is filed in the medical record

- A signed release of medical records

**Organization**

- The medical record is legible to someone other than the writer
- Each patient has an individual medical record
- Chart pages are bound, clipped, or attached to the file
- Chart selections are easily recognized for retrieval of information (i.e. lab section, encounter notes, correspondence)

**Retrieval**

- Medical record is available to practitioner at each encounter
- Medical record is available to Molina Healthcare for purposes of Quality Improvement
- Medical record retention is at least eight years per OAC 5160-25 and 5160-26-06
- Data recovery procedure functions in the event of data loss (i.e. fire, vandalism, system failure)

**Confidentiality**

- Medical records are protected from unauthorized access
- Access to computerized confidential information is restricted
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information (PHI)

**I. Office Site Visit – Clinical Review**

Molina Healthcare performs site assessments on practitioner offices about which member or other complaints have been received and implements corrective action and follow-up in compliance with regulatory and accreditation standards. Office sites are assessed based on the following criteria:

**Physical Access/Safety Survey Criteria**

- Accommodations for persons with disabilities are guided by ADA standards, evidenced by designated parking, loading zone, an external ramp, and/or public transportation within close proximity to the building. Reviewer to consider regional site characteristics.
- Parking areas and walkways demonstrate appropriate maintenance.
- Reasonable accommodations guided by ADA standards for persons with disabilities include all of the following:
  - Automatic entry option or alternative access method
  - Elevator for public use (if applicable)
  - Restroom equipped with large stall and safety bars or other reasonable accommodation
- At least one exam room can accommodate physically challenged patients.
- Fire protection equipment (fire extinguisher, smoke detector, fire alarm, or sprinkler system) is accessible and in working order and are inspected on a yearly basis.

- Emergency medications (injectable epinephrine, Benadryl) are available on-site and current (i.e. have not expired).
- A medication dosage chart (or other method for determining dosage) is kept with emergency medications.
- There is a procedure for the management of non-medical emergencies.
- There is a procedure for handling medical emergencies appropriate to the patient population.
- If a crash cart is available:
  - All medications are current
  - Airway management, oxygen delivery system, oral airways, nasal cannula or mask, and/or ambu bag are available
- At least one physician or CPR certified employee is available at all times during patient visits.

### **Physical Appearance**

- Exam rooms are in good repair and have exam tables with protective barriers.
- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis.
- Office has a well-lighted waiting area and entry way.

### **Adequacy of Waiting and Exam Room Space**

- Adequate seating is provided in waiting room for an average number of patients in an hour.
- Exam rooms provide privacy for members.
- Exam rooms provide adequate seating and physical assessment space.

### **Medical Record Keeping Survey Criteria**

- Medical records are secured from patient and public access and are restricted to identified staff.
- Medical record release procedures are compliant with state and federal regulations (N/A if provider utilizes electronic medical record, or EMR.)
- Patient records are available for each encounter.
- There is an individual record for each patient.
- Forms and methodology for filing within a chart are consistent.
- Allergies and reaction or no known allergies (NKA) are clearly indicated on each chart.
- Discussion about Advance Directives is documented for patients age 18 and over.
- The patient name appears on each sheet in the chart (N/A for EMR).
- There is a date and signature or initial on each entry/report in the chart.
- There is a procedure for documenting medical doctor (MD) review and patient notification prior to filing lab, x-ray, and other reports in the chart.
- There is a procedure for documenting patient phone communications.
- Medical records are retained for a minimum of seven years.



**Personnel Survey Criteria**

- There is evidence that staff receive orientation/training about the policies and procedures relevant to their job descriptions.
- Appropriate licensure or certification is current and available (as applicable for RN, NP, LVN, PA, MA, technicians)
- Staff signs Confidentiality Agreements at the time of hire.

**Office Management Survey Criteria**

- Office hours are posted or are available on request.
- There is a provision for 24-hour, seven days per week coverage.
- The average wait time is less than 30 minutes from the scheduled appointment time.
- Urgent visits are scheduled within 24 hours, and emergency care is immediately available or referred to 911 or directed to emergency department (ED).
- Preventive exam appointments are scheduled within six weeks and policy in place for reminder for preventive care (i.e. immunizations, pap smears, mammograms, etc.)
- Initial visit for pregnancy is available within two to four weeks.
- Specialty care routine consultation is available within six to eight weeks.
- Behavioral Health visits for non-life threatening emergency are scheduled within six hours.
- Behavioral Health visits for Urgent Care are scheduled within 48 hours.
- Behavioral Health visits for Routine Care are scheduled within 10 business days.
- There is a policy to follow up on missed appointments.
- There is a policy for compliance with HIPAA privacy regulations including evidence that the disclosure of privacy practices is signed by patient and posted.

**Clinical Service Survey Criteria**

- The following are inaccessible to patients:
  - Prescription pads
  - Needles
  - Syringes
  - Medications
- Narcotics are stored in a secured locked cabinet accessible to only authorized licensed personnel.
- A current inventory is maintained for each controlled substance.
- Medications (including samples) are checked monthly for expiration dates.
- There is a policy for disposal of expired medications.
- Refrigerator thermometer temperature is maintained and documented daily at 35° to 46° Fahrenheit.
- Freezer thermometer temperature is maintained and documented daily at -58° to 5° Fahrenheit if varicella vaccine is present.
- VFC immunization vials are stored according to manufacturer requirements.
- Drugs are stored in a separate refrigerator from food and drinks.
- Clinical Laboratory Improvement Amendments (CLIA) certificate number or CLIA Waiver is current (if applicable).

- Laboratory supplies are inaccessible to unauthorized persons.
- X-ray license(s) is/are current.
- X-ray equipment maintenance documentation is current.

### **Preventive Services Survey Criteria**

- Exam rooms are in good repair and have exam tables with protective barriers.
- The office has age-appropriate equipment, including but not limited to:
  - Weight scale (infant and adult)
  - Length/height measuring devices
  - Sphygmomanometer in various sizes (child, adult, obese)
  - Thermometer
  - Exam gowns
  - Eye chart
  - Ophthalmoscope
  - Otoscope with adult and pediatric ear speculum
- Educational materials are:
  - Available for patients
  - Age appropriate for the patient population
  - Language appropriate for the patient population (if more than 10 percent of patient base is English Second Language)

### **Infection Control Survey Criteria**

- The following autoclave processes are documented (as applicable):
  - Routine maintenance (inspection dates, service results, calibration, repairs, etc.)
  - Spore checks conducted at least monthly
- The following cold chemical sterilization processes are documented (as applicable):
  - Containers dated
  - Solutions used must kill HIV, HBV, TB
  - Solutions used according to product label
- Soap or antiseptic hand cleaner and running water are available in treatment areas for hand washing.
- The sterilization date is listed on sterilized packages.
- Specimens requiring refrigeration are stored in sealed containers and separate from drugs and food.
- There is a needle disposable system available.
- There is a policy for the handling of bio-hazardous waste.
- There is a contract or written agreement for the secured disposal of bio-hazardous waste.
- Bio-hazardous waste is stored in rigid, leak-resistant containers.

### **J. Advance Directives (Patient Self-Determination Act)**

Under Ohio law, there are three types of Advance Directives:

- Living Will – Allows patients to put wishes about medical care in writing for situations when they are unable to make these wishes known.
- Declaration for Mental Health Treatment – Allows patients to appoint a proxy to make decisions specifically about mental health treatment on their behalf when they lack the capacity to make these decisions.
- Durable Power of Attorney – Allows patients to choose a representative to carry out their wishes regarding medical care when they cannot act for themselves.

Providers must honor Advance Directives to the fullest extent of the law. In no event may a provider refuse to treat a patient or otherwise discriminate against a patient because the patient has completed an Advance Directive. However, Ohio law includes a conscience clause. If a provider cannot follow an Advance Directive because it goes against his or her conscience, he or she must assist the patient in finding another provider who will carry out the patient's wishes. Under Ohio law, patients have the right to file a complaint related to Advance Directives with the Ohio Department of Health.

Practitioners/providers must inform adult Molina Healthcare members of their right to make health care decisions and execute Advance Directives. It is important that members are informed about Advance Directives. During routine medical record review, Molina Healthcare auditors will look for documented evidence of a discussion between the practitioner or provider and the member. Molina Healthcare will notify the provider via phone or fax of an individual member's Advance Directives if identified through care management or care coordination. Providers are instructed to document the presence of an Advance Directives in a prominent location of the medical record. Auditors will also look for copies of the Advance Directives form. Advance Directives forms are state specific to meet state regulations.

Each Molina Healthcare practitioner/provider must honor Advance Directives to the fullest extent permitted by law. Members may select a new PCP if the assigned provider has an objection to the beneficiary's desired decision. Molina Healthcare will facilitate finding a new PCP or specialist as needed.

PCPs must discuss Advance Directives with a member and provide appropriate medical advice if the member desires guidance or assistance. Molina Healthcare's network practitioners and facilities are expected to communicate any objections they may have to a member directive prior to service whenever possible. In no event may any practitioner/provider refuse to treat a member or otherwise discriminate against a member because the member has completed an Advance Directives. CMS law gives members the right to file a complaint with Molina Healthcare or the state survey and certification agency if the member is dissatisfied with Molina Healthcare's handling of Advance Directives and/or if a practitioner/provider fails to comply with Advance Directives instructions.

## **K. Clinical Practice Guidelines**

Molina Healthcare adopts and disseminates [Clinical Practice Guidelines](#) (CPG) to reduce inter-practitioner/provider variation in diagnosis and treatment. All guidelines are based on scientific evidence, review of medical literature and/or appropriate established authority. CPGs are reviewed annually and are updated as new recommendations are published.

Molina Healthcare CPGs include the following:

Acute Respiratory Tract Infection - Adult	Coronary and Other Vascular Disease
ADHD - School-age Children and Adolescents	Depression
Asthma	Diabetes
COPD	Hypertension

On an annual basis, [CPGs](#) are distributed to practitioners/providers via [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com) and this Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Healthcare [Partners in Care provider newsletter](#) and/or [Provider Bulletin](#). Individual practitioners or members may request copies from the Quality Improvement department by contacting a Provider Relations Representative.

#### **L. Preventive Health Guidelines**

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

- Mammography screening
- Prostate cancer screening
- Cholesterol screening
- Influenza, pneumococcal and hepatitis vaccines
- Childhood and adolescent immunizations
- Cervical cancer screening
- Chlamydia screening
- Prenatal visits

The following [Preventive Health Guidelines](#) and HEDIS<sup>®</sup> Guidelines for preventive care can be found at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com):

- Infants, Children and Adolescents
- Adults 22 to 64 Years
- Seniors 65 Years and Older
- Pregnancy
- HEDIS<sup>®</sup> Tip Sheets

All guidelines are updated with each release by USPSTF and are approved by the Clinical Quality Improvement Committee. On an annual basis, [Preventive Health Guidelines](#) are distributed to practitioners/providers via [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com) and this Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Healthcare [Partners in Care provider newsletter](#) and/or [Provider Bulletin](#).

#### **M. EPSDT Services to Enrollees Under 21 Years**

Molina Healthcare maintains systematic and robust monitoring mechanisms to ensure all required EPSDT services to enrollees less than 21 years are timely according to required guidelines. All enrollees under 21 years of age should receive screening examinations including appropriate childhood immunizations at intervals as specified by the EPSDT program as set forth in §§1902(a)(43) and 1905(a)(4)(B) of the Social Security Act and 89 III. Adm. Code 140.485. Molina Healthcare's Quality Improvement department is available to perform provider training to ensure that best practice guidelines are followed in relation to well child services and care for acute and chronic health care needs. Contact your Provider Relations Representative if you would like more information.

#### **N. Well Child/Adolescent Visits**

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

- Comprehensive health history
- Nutritional assessment
- Height, weight and growth charting
- Comprehensive unclothed physical examination
- Immunizations
- Laboratory procedures, including lead toxicity testing
- Periodic objective developmental screening using a recognized, standardized developmental screening tool
- Objective vision and hearing screening
- Risk assessment
- Anticipatory guidance
- Periodic objective screening for social emotional development using a recognized, standardized tool, as approved by DCH
- Perinatal depression for mothers of infants in the most appropriate clinical setting, e.g., at the pediatric, behavioral health or OB/GYN visit

Any condition discovered during the screening examination or screening test requiring further diagnostic study or treatment must be provided if within the member's covered benefit services. Members will be referred to an appropriate source of care for any required services that are not covered services. Molina Healthcare shall have no obligation to pay for services that are not covered services.

#### **O. Measurement of Clinical and Service Quality**

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

- HEDIS<sup>®</sup>
- CAHPS<sup>®</sup>
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Activities

Interdisciplinary teams analyze all service and process improvement opportunities and programs and determine actions for improvement evaluating results. Molina Healthcare's most recent results can be obtained from your local Molina Healthcare QI department by contacting your Provider Relations Representative. Also, PCPs can obtain their HEDIS<sup>®</sup> score card through the Molina Healthcare Provider Provider Portal.

#### **P. Cultural and Linguistic Services**

Molina Healthcare serves a diverse population of members with specific cultural needs and preferences. All eligible members who are Limited English Proficient (LEP) are entitled to receive interpreter services. A LEP individual has a limited ability or inability to read, speak, or write English well enough to understand and communicate effectively (whether because of language, cognitive or physical limitations).

Molina Healthcare members are entitled to:

- Be provided with effective communications with medical providers as established by the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and the Civil Rights Act of 1964.
- Be given access to Care Managers trained to work with cognitively impaired individuals.
- Be notified by the medical provider that interpreter services are available at no cost to the client.
- Decide, with the medical provider, to use an interpreter and receive unbiased interpretation.
- Be assured of confidentiality, as follows:
  - Interpreters must adhere to Health and Human Service Commission (HHSC) policies and procedures regarding confidentiality of client records.
  - Interpreters may, with client written consent, share information from the client's records only with appropriate medical professionals and agencies working on the client's behalf.
  - Interpreters must ensure that this shared information is similarly safeguarded.
- Have interpreters, if needed, during appointments with the member's providers and when talking to the health plan.

Interpreters include people who can speak the member's native language, assist with a disability, or help the member understand the information.

Pursuant to Title VI of the Civil Rights Act of 1964, services provided for members with LEP, LRP or limited hearing or sight are the financial responsibility of the provider. Under no circumstances are Molina Healthcare members responsible for the cost of such services. Written procedures are to be maintained by each office or facility regarding their process for obtaining such services.

When Molina Healthcare members need interpreter, limited hearing and/or limited reading services for health care services, the provider should:

- Verify the member's eligibility and medical benefits.
- Inform the members that interpreter, limited hearing and/or limited reading services are available.
- Follow written procedures for accessing such services, which may include: Language Line (800) 752-6096, Voiance (866)743-9010 or Trusted Translations (877) 255-0717\*.
- Molina Healthcare is available to assist providers with locating these services if needed.
  - Providers needing assistance finding onsite interpreter services may call Molina Healthcare Member Services.
  - Providers needing assistance finding translation services may call Molina Healthcare Member Services.
  - Providers with members who cannot hear or have limited hearing ability may use the Ohio Relay service (TTY) at () 711.
  - Providers with members with limited vision may contact Molina Healthcare Member Services for documents in large print, Braille or audio version.
  - Providers with members with limited reading proficiency (LRP) may contact Molina Healthcare Member Services. The Molina Healthcare Member Service Representative will verbally explain the information, up to and including reading the documentation to the members or offer the documents in audio version
  - Contact Molina Healthcare Members Services at:
    - Medicaid: (800) 642-4168 (TTY/Ohio Relay (800) 750-0750 or 711), Monday through Friday from 7 a.m. to 7 p.m.
    - Molina Dual Options (full benefits): (855) 665-4623 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.
    - Molina MyCare Ohio Medicaid (opt-out): (855) 687-7862 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.

Providers using interpreter services shall document such services. Documentation of these services shall be kept in the member's chart, which may be audited by Molina Healthcare.

Molina Healthcare asks providers to inform us when providing interpreter services to Molina Healthcare members. This information will be added to the member's record for future reference if needed. Providers may report this information to Molina Healthcare by calling Molina Healthcare Member Services.

## VIII. Compliance

### A. Health Insurance Portability and Accountability Act (HIPAA)

#### **Molina Healthcare's Commitment to Patient Privacy**

Protecting the privacy of members' personal health information is a core responsibility that Molina Healthcare takes very seriously. Molina Healthcare is committed to complying with all federal and state laws regarding the privacy and security of members' protected health information (PHI). Molina Healthcare provides its members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Molina Healthcare uses and discloses our members' PHI and includes a summary of how Molina Healthcare safeguards their PHI. A sample of the Privacy Summary and Notice of Privacy Practices that we provide to Molina Duals Options MyCare members is included at the end of this section. To view our Notice of Privacy Practices for our Medicaid members, please visit our website at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com).

#### **Provider/Practitioner Responsibilities**

Molina Healthcare expects that its contracted provider will respect the privacy of Molina Healthcare members (including Molina Healthcare members who are not patients of the provider) and comply with all applicable laws and regulations regarding the privacy of patient and member PHI.

#### **Applicable Laws**

Providers must understand all state and federal health care privacy laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead there is a patchwork of laws with which providers must comply. In general, most health care providers are subject to various laws and regulations pertaining to privacy of health information, which may include, but are not limited to, the following:

1. Federal Laws and Regulations
  - a. HIPAA
  - b. The Health Information Technology for Economic and Clinical Health Act (HITECH)
  - c. Medicare and Medicaid laws
  - d. The Affordable Care Act
2. Applicable State Laws and Regulations



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

### **Uses and Disclosures of PHI**

Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a provider may use and disclose PHI for their own treatment, payment and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI.

Uses and disclosures for TPO apply not only to the provider's own TPO activities, but also for the TPO of another covered entity. Disclosure of PHI by one covered entity to another covered entity, or health care provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services."
2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:
  - a. Quality improvement
  - b. Disease management
  - c. Care management and care coordination
  - d. Training programs
  - e. Accreditation, licensing and credentialing

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

See sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.  
See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule.

### **Inadvertent Disclosures of PHI**

Molina Healthcare may, on occasion, inadvertently misdirect or disclose PHI pertaining to Molina Healthcare member(s) who are not the patients of the provider. In such cases, the provider shall return or securely destroy the PHI of the affected

Molina Healthcare members in order to protect their privacy. The provider agrees to not further use or disclose such PHI, unless otherwise permitted by law.

### **Written Authorizations**

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

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

### **Notice of Privacy Practices**

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

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

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

ii. **Requests for Confidential Communications**

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

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

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

iv. **Request to Amend PHI**

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

v. **Request Accounting of PHI Disclosures**

Patients may request an accounting of disclosures of PHI made by the provider during the preceding six-year period. The list of disclosures does

not need to include disclosures made for treatment, payment, or health care operations or made prior to April 14, 2003.

### **HIPAA Security**

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

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

### **HIPAA Transactions and Code Sets**

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

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

Molina Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers who wish to conduct HIPAA standard transactions with Molina Healthcare you should visit our website at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com) to view additional information. Providers can navigate to this informative page starting from Molina Healthcare's website:

1. Select the area titled "Health Care Professionals."
2. Select the appropriate line of business.
3. From the top of the web page, click the tab titled "HIPAA."
4. Click on the tab titled "HIPAA Transaction Readiness."

### **Code Sets**

HIPAA regulations require that only approved code sets may be used in standard electronic transactions. For claims with dates of service prior to Oct. 1, 2015, ICD-9

coding must be used. For claims with dates of service on or after Oct. 1, 2015, providers must use the ICD-10 code sets.

### **About ICD-10**

ICD-10-CM/PCS (International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System) consists of two parts:

1. ICD-10-CM for diagnosis coding
2. ICD-10-PCS for inpatient procedure coding

ICD-10-CM is for use in all U.S. health care settings. Diagnosis coding under ICD-10-CM uses three to seven digits instead of the three to five digits used with ICD-9-CM, but the format of the code sets is similar.

ICD-10-PCS is for use in U.S. inpatient hospital settings only. ICD-10-PCS uses seven alphanumeric digits instead of the three or four numeric digits used under ICD-9-CM procedure coding. Coding under ICD-10-PCS is much more specific and substantially different from ICD-9-CM procedure coding.

### **National Provider Identifier**

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

### **Additional Requirements for Delegated Providers**

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

### **Patient Rights**

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

1. Notice of Privacy Practices  
Providers/practitioners that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of

privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The provider/practitioner should obtain a written acknowledgment that the patient received the notice of privacy practices.

2. Requests for Restrictions on Uses and Disclosures of PHI  
Patients may request that a health care provider/practitioner restrict its uses and disclosures of PHI. The provider/practitioner is not required to agree to any such request for restrictions.
3. Requests for Confidential Communications  
Patients may request that a health care provider/practitioner communicate PHI by alternative means or at alternative locations. Providers/practitioners must accommodate reasonable requests by the patient.
4. Requests for Patient Access to PHI  
Patients have a right to access their own PHI within a provider/practitioner's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a provider/practitioner includes the patient's medical record, as well as billing and other records used to make decisions about the member's care or payment for care.
5. Request to Amend PHI  
Patients have a right to request that the provider/practitioner amend information in their designated record set.
6. Request Accounting of PHI Disclosures  
Patients may request an accounting of disclosures of PHI made by the provider/practitioner during the preceding six-year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations or made prior to April 14, 2003.

### **HIPAA Security**

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

In addition, medical identity theft is an emerging threat in the health care industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity—such as health insurance information—without the person's knowledge or consent to obtain health care services or goods. Medical

identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Molina Healthcare.

### **HIPAA Transactions and Code Sets**

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

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

Molina Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers/practitioners who wish to conduct HIPAA standard transactions with Molina Healthcare should refer to Molina Healthcare's website at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com) for additional information. Click on the area titled "For Health Care Professionals," click the tab titled "HIPAA" and then click on the tab titled "Transactions Readiness" or "HIPAA Code Sets."

### **National Provider Identifier**

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

### **Additional Requirements for Delegated Providers/Practitioners**

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

### **Privacy Summary and Notice of Privacy Practices**

Dear Molina Member:

Your privacy is important to us. We respect and protect your privacy. Molina uses and shares your information to provide you with health benefits. Molina wants to let you know how your information is used or shared.

PHI means protected health information. PHI is health information that includes your name, member number or other identifiers, and is used or shared by Molina.

*Why does Molina use or share our Members' PHI?*

- To provide for your treatment
- To pay for your health care
- To review the quality of the care you get
- To tell you about your choices for care
- To run our health plan
- To use or share PHI for other purposes as required or permitted by law

*When does Molina need your written authorization (approval) to use or share your PHI?*

Molina needs your written approval to use or share your PHI for purposes not listed above.

*What are your privacy rights?*

- To look at your PHI
- To get a copy of your PHI
- To amend your PHI
- To ask us to not use or share your PHI in certain ways
- To get a list of certain people or places we have shared your PHI with

*How does Molina protect your PHI?*

Molina uses many ways to protect PHI across our health plan. This includes PHI in written word, spoken word, or in a computer. Below are some ways Molina protects PHI:

- Molina has policies and rules to protect PHI.
- Molina limits who may see PHI. Only Molina staff with a need to know may use it.
- Molina staff is trained on how to protect and secure PHI.
- Molina staff must agree in writing to follow the rules and policies that protect and secure PHI.
- Molina secures PHI in our computers. PHI in our computers is kept private by using firewalls and passwords.

*What must Molina do by law?*

- Keep your PHI private.
- Give you written information, such as this on our duties and privacy practices about your PHI.
- Follow the terms of our Notice of Privacy Practices.

*What can you do if you feel your privacy rights have not been protected?*

- Call or write Molina and complain.
- Complain to the Department of Health and Human Services.
- We will not hold anything against you. Your action would not change your care in any way.

The above is only a summary. Our Notice of Privacy Practices has more information about how we use and share our members' PHI. Our Notice of Privacy Practices is in the following section of this document. It is on our web site at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com). You may also get a copy of our Notice of Privacy Practices by calling our Member Services department at (855) 665-4623, Monday-Friday, 8 a.m. to 8 p.m. local time. TTY/TDD users, please call 711.

You can get this information for free in other languages. Call (855) 665-4623, TTY/TDD 711. The call is free.

Usted puede recibir esta información en otros idiomas gratuitamente. Llame al (855) 665-4623, TTY/TDD 711. Esta es una llamada gratuita.

### Categories of Permitted Uses & Disclosures of PHI

<b>TREATMENT (T)</b>	<b>PAYMENT (P)</b>	<b>HEALTH CARE OPERATIONS (HCO)</b>	<b>OTHER PERMITTED USES &amp; DISCLOSURES (OP)</b>
Referrals  Provision of care by providers	1. Eligibility verification 2. Enrollment/disenrollment 3. Claims processing and payment 4. Coordination of benefits 5. Subrogation 6. Third party liability 7. Encounter data 8. Member utilization management (UM)/claims correspondence 9. Capitation payment and processing 10. Collection of premiums or reimbursements	1. Quality assessment and improvement: <ul style="list-style-type: none"> <li>▪ Member satisfaction surveys</li> <li>▪ Population based QI studies</li> <li>▪ HEDIS<sup>®</sup> measures</li> <li>▪ Development of clinical guidelines</li> <li>▪ Health improvement activities</li> <li>▪ Care management</li> </ul> Contacting providers and members about treatment alternatives <ul style="list-style-type: none"> <li>▪ Disease management</li> </ul> 2. Credentialing and accreditation: <ul style="list-style-type: none"> <li>▪ Licensing</li> <li>▪ Provider credentialing</li> <li>▪ Accreditation (e.g., NCQA)</li> </ul>	1. Public Health: <ul style="list-style-type: none"> <li>▪ Reporting to immunization registries</li> <li>▪ Reporting of disease and vital events</li> <li>▪ Reporting of child abuse or neglect</li> <li>▪ Report adverse events for FDA-regulated products</li> <li>▪ Victims of abuse, neglect or domestic violence (except for child abuse) to regulators (e.g., Ohio Department of Insurance) for Health Care Oversight, including audits, civil and criminal</li> </ul>



	<ul style="list-style-type: none"> <li>11. Drug rebates</li> <li>12. Reinsurance claims</li> <li>13. UM: <ul style="list-style-type: none"> <li>▪ Pre-authorizations</li> <li>▪ Concurrent reviews</li> <li>▪ Retrospective reviews</li> <li>▪ Medical necessity reviews</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Evaluating provider or practitioner performance</li> <li>3. Underwriting or contract renewal</li> <li>4. Auditing – conducting or arranging for: <ul style="list-style-type: none"> <li>▪ Auditing</li> <li>▪ Compliance</li> <li>▪ Legal</li> <li>▪ Fraud and abuse detection</li> <li>▪ Medical review</li> </ul> </li> <li>5. Business planning and development: <ul style="list-style-type: none"> <li>▪ Cost management</li> <li>▪ Budgeting</li> <li>▪ Formulary development</li> <li>▪ Mergers and acquisitions, including due diligence</li> </ul> </li> <li>6. Business management and General administrative activities: <ul style="list-style-type: none"> <li>▪ Member Services, including complaints and grievances and member materials fulfillment</li> <li>▪ De-identification of data</li> <li>▪ Records and document management (if the documents contain PHI)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>investigations</li> <li>2. Judicial and administrative proceedings: <ul style="list-style-type: none"> <li>▪ Court orders</li> <li>▪ Subpoenas and discovery requests (without court order)</li> <li>▪ Workers’ compensation</li> </ul> </li> <li>3. Disclosures for law enforcement: <ul style="list-style-type: none"> <li>▪ Court ordered warrants and summons</li> <li>▪ Grand jury subpoenas</li> <li>▪ Identification and location purposes</li> </ul> </li> <li>4. Information about decedents: <ul style="list-style-type: none"> <li>▪ To coroners and medical examiners</li> <li>▪ To funeral directors</li> <li>▪ Organ donation</li> </ul> </li> <li>5. Research (e.g., clinical trials)</li> <li>6. Special government functions: <ul style="list-style-type: none"> <li>▪ Military activities</li> <li>▪ National security</li> <li>▪ Protective services for the President</li> </ul> </li> </ul>
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## B. Fraud Waste and Abuse Program

### Introduction

Molina Healthcare of Ohio maintains a comprehensive Fraud, Waste, and Abuse program. The program is held accountable for the special investigative process in accordance with federal and state statutes and regulations. Molina Healthcare is dedicated to the detection, prevention, investigation and reporting of potential health care fraud, waste, and abuse. As such, the Compliance department maintains a comprehensive plan, which addresses how Molina Healthcare will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. The

program also addresses fraud prevention and the education of appropriate employees, vendors, providers and associates doing business with Molina Healthcare.

### **Mission Statement**

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

### **Regulatory Requirements**

#### Federal False Claims Act

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

The term “knowing” is defined as a person with respect to information:

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

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

#### Deficit Reduction Act

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

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

- The Federal False Claims Act and state laws pertaining to submitting false claims
- How providers will detect and prevent fraud, waste, and abuse

- Employee protection rights as 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 acts. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

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

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

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

## **DEFINITIONS**

### Fraud

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

### Waste

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

### Abuse

“Abuse” means provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary costs to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet

professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid programs. (42 CFR § 455.2)

#### Examples of Fraud, Waste and Abuse by a provider

- Billing for services, procedures and/or supplies that have not actually been rendered
- Providing services to patients that are not medically necessary
- Balance billing a Medicaid member for Medicaid covered services. For example, asking the patient to pay the difference between the discounted fees, negotiated fees and the provider's usual and customary fees.
- Intentional misrepresentation or manipulating the benefits payable for services, procedures and/or supplies, dates on which services and/or treatments were rendered, medical record of service, condition treated or diagnosed, charges or reimbursement, identity of provider/practitioner or the recipient of services, "unbundling" of procedures, non-covered treatments to receive payment, "up-coding," and billing for services not provided
- Concealing patient's misuse of Molina Healthcare identification card
- Failure to report a patient's forgery/alteration of a prescription
- Knowingly and willfully soliciting/receiving payment of kickbacks or bribes in exchange for the referral of Medicaid patients
- A physician knowingly and willfully referring Medicaid patients to health care facilities in which or with which the physician has a financial relationship (The Stark Law)

#### **Review of Provider**

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

- Federal and state Medicaid sanction reports
- Federal and state lists of excluded individuals and entities including the U.S. Department of Health and Human Services Office of the Inspector General Exclusion Database and the Ohio Department of Medicaid Provider Exclusion and Suspension List. List of parties excluded from Federal Procurement and Non-procurement Programs
- Medicaid suspended and ineligible provider list
- Monthly review of state Medical Board sanctions list
- Review of license reports from the appropriate specialty board

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

**Provider/Practitioner Education**

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

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

**Review of Provider Claims and Claims System**

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

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

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

**Reporting Fraud, Waste and Abuse**

If you suspect cases of fraud, waste or abuse, you must report it by contacting the Molina Healthcare AlertLine. AlertLine is an external telephone and web-based reporting system hosted by NAVEX Global, a leading provider of compliance and ethics hotline services. AlertLine telephone and web-based reporting is available 24 hours a day, seven days a week and 365 days a year.

When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina Healthcare Compliance department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to AlertLine can be made from anywhere within the United States with telephone or Internet access.

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

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

Molina Healthcare of Ohio  
Attn: Compliance  
P.O. Box 349020  
Columbus, OH 43234

Remember to include the following information when reporting:

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

Suspected fraud and abuse may also be reported directly to the state. If you suspect that a Medicaid recipient has committed fraud or abuse and would like to report it, please contact the County Department of Job and Family Services (CDJFS) in which the beneficiary resides. The number can be found in the CDJFS directory at [www.jfs.ohio.gov/county/county\\_directory.pdf](http://www.jfs.ohio.gov/county/county_directory.pdf) or in the telephone book under "County Government." If you are unable to locate the number, please call the Ohio Department of Job and Family Services General Information Customer Service number at (877) 852-0010 for assistance.

If you suspect a provider to have committed fraud or abuse of the Medicaid program, or have specific knowledge of corrupt or deceptive practices by a provider, you should contact the Ohio Attorney General's Medicaid Fraud Control Unit at (614) 466-0722 or the Attorney General's Help Center at (800) 282-0515.

## **IX. Members Rights and Responsibilities**

Molina Healthcare members have certain rights and responsibilities to ensure that they get the most out of their health care experience. Rights and responsibilities are communicated to members through the Molina Healthcare Member Handbook, the Molina Healthcare website and an annual mailing to all members. Providers and their staff are encouraged to be familiar with these rights and responsibilities.

### **A. Medicaid Members' Rights**

As a member of Molina Healthcare, you have the following rights:

1. To receive all services that Molina Healthcare must provide.
2. To be treated with respect and with regard for your dignity and privacy.
3. To be sure that your medical record information will be kept private.

4. To be given information about your health. This information may also be available to someone whom you have legally okayed to have the information or whom you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
5. To be able to take part in decisions about your health care. To get information on any medical care treatment, given in a way that you can follow.
6. To be sure that others cannot hear or see you when you are getting medical care.
7. To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge.
8. To ask and get a copy of your medical records and to be able to ask that the record be changed/corrected if needed.
9. To be able to say "yes" or "no" to having any information about you given out unless Molina Healthcare has to by law.
10. To be able to say "no" to treatment or therapy. If you say "no," the doctor or MCP must talk to you about what could happen, and they must put a note in your medical record about it.
11. To be able to file an appeal, a grievance (complaint) or state hearing. (See the [Appeals and Grievances section](#) for information.)
12. To be able to get all MCP written member information from the MCP:
  - a. at no cost to you;
  - b. in the prevalent non-English languages of members in the MCP's service area;
  - c. in other ways, to help with the special needs of members who may have trouble reading the information for any reason.
13. To be able to get help free of charge from Molina Healthcare and its providers if you do not speak English or need help in understanding information.
14. To be able to get help with sign language at no cost.
15. To be told if the health care provider is a student and to be able to refuse his/her care.
16. To refuse to be part of experimental care.
17. To make Advance Directives (a living will; see the [Provider Responsibilities section](#) for more information). You can also contact Member Services for more information.
18. To file any complaint about not following your advance directives with the Ohio Department of Health.
19. To change your PCP to another PCP on Molina Healthcare's panel at least monthly. Molina Healthcare must send you something in writing that says who the new PCP is and the date the change began.
20. To be free to carry out your rights and know that the MCP, the MCP's providers or ODM will not hold this against you.
21. To know that the MCP must follow all federal and state laws and other laws about privacy that apply.
22. To choose the provider that gives you care whenever possible and appropriate.

23. If you are a female, to be able to go to a women's health provider on Molina Healthcare's panel for covered women's health services.
24. To be able to get a second opinion from a qualified provider on Molina Healthcare's panel. If a qualified provider is not able to see you, Molina Healthcare must set up a visit with a provider not on our panel at no cost to you.
25. To get information about Molina Healthcare from us.
26. To contact the United States Department of Health and Human Services Office of Civil Rights and/or the Ohio Department of Job and Family Services Bureau of Civil Rights at the addresses listed below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran status, ancestry, health status, or need for health services.

Office for Civil Rights  
United States Department of Health and Human Services  
233 N. Michigan Ave. – Suite 240  
Chicago, Illinois 60601  
(312) 886-2359; (312) 353-5693 TTY

Bureau of Civil Rights  
Ohio Department of Job and Family Services  
30 E. Broad St., 30th Floor  
Columbus, Ohio 43215  
(614) 644-2703; 1-866-227-6353; 1-866-221-6700 TTY  
Fax: (614) 752-6381

**You also have the right to:**

- Receive information about Molina Healthcare, covered benefits and the providers contracted to provide services.
- Openly discuss your treatment options, regardless of cost or benefit coverage, in a way that is easy to understand.
- Receive information about your member rights and responsibilities.
- Make recommendations about Molina Healthcare's member rights and responsibilities policies.
- Get a second opinion from a qualified provider on Molina Healthcare's panel. Molina Healthcare must set up a visit with a provider not on our panel at no cost to you, if a qualified panel provider is not able to see you.

**B. MyCare Ohio Members' Rights:**

1. Members have the right to be treated with respect and recognition of their dignity by everyone who works with and for Molina Dual Options program.
2. Members have the right to receive information about Molina Dual Options program, covered benefits, our providers, our doctors, our services and member's rights and responsibilities.



3. Members have the right to choose their primary care physician (PCP) that gives care whenever possible and appropriate from Molina Dual Options network and the provision to change PCP on the Molina Dual Options network at least monthly. Molina Dual Options program must communicate all changes in writing as to who the new PCP is and the effective date of change.
4. Members have the right to receive and/or to authorize representative(s) to obtain information about their health in simple and understandable terminology and/or nominate contact(s) to be reached in case of emergency. If members are ill, members have the right to be told about treatment options regardless of cost or benefit coverage. Members have the right to have all questions about their health answered.
5. Members have the right to help make decisions about their health care. Members have the right to refuse medical treatment.
6. Members have the right to privacy. Molina, its Staff and affiliates keeps their medical records private in accordance with State and Federal laws.
7. Members have the right to see their medical record. Members have the right to receive a copy of their medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.
8. Members have the right to complain about Molina Dual Options program or their care by calling, faxing, e-mailing or writing to Molina Dual Options Member Services Department.
9. Members have the right to appeal Molina Dual Options decisions. Members have the right to have someone speak for them during the grievance.
10. Members have the right to disenroll from Molina Dual Options.
11. Members have the right to ask for a second opinion about their health condition from a qualified provider on Molina Healthcare's plan. If the qualified provider is not able to provide service to member, Molina Dual Options must set up a visit with a provider not on our panel. These services are available at no extra cost to member.
12. Members have the right to ask for an external independent review of experimental or investigational therapies.
13. Members have the right to decide in advance directives (a living will) on how they want to be cared for in case they have a life-threatening illness or injury.
14. Members have the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
15. Members have the right to receive interpreter services at no cost to help them talk with their doctor or Molina Dual Options interpreter if they prefer to speak a language other than English and get help with sign language if hearing impaired.
16. Members have the right to not be asked to bring a friend or family member with them to act as their interpreter.
17. Members have the right to receive information about the Molina Dual Options program, their providers, or their health in their preferred language free of charge. Members have the right to request information in printed form translated into their preferred language.

18. Members also have the right to request and receive informational materials in alternative formats (including Braille, large size print, and audio format) upon request and in a timely fashion appropriate for the format being requested at no cost to member.
19. Members have the right to receive a copy of Molina Dual Options program drug formulary on request.
20. Members have the right to access minor consent services.
21. Members have the freedom to exercise these rights without negatively affecting how they are treated by Molina Dual Options program staff, its providers, consistent with CMS and regulations for those states that are participating in the MMP demonstration plan. There are disciplinary procedures for staff members who violate this policy.
22. Members have a right to make recommendations regarding the organization's member rights and responsibilities policies.
23. Members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
24. Members have the right to file a grievance or complaint if they believe their linguistic needs were not met by the plan.
25. Members have the right to receive instructions on how they can view online, or request a copy of Molina Dual Options program non-proprietary clinical and administrative policies and procedures.
26. Female members should be able to go to a women's health provider on Molina Dual Options panel for covered Women's health services.
27. Molina Dual Options program's staff and its providers will not discriminate against enrollees due to Medical condition (including physical and mental illness) or for any of the following: claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.
28. Members have the right to contact the United States Department of Health and Human Services Office of Civil Rights and/or their local office for Civil Rights with any complaints of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status, or need for health services.
29. Members have the right to reasonable accommodation in order to access care.

### **C. Membership Responsibilities**

As a member of Molina Healthcare, you have the responsibility to:

1. Always carry your Molina Healthcare ID card, and not let anyone else use your ID card.
2. Keep appointments, and be on time.
3. If you require transportation, call Molina Healthcare at least 48 hours in advance, whenever possible.
4. Call your provider 24 hours in advance if you are going to be late or if you cannot keep your appointment.

5. Share important health information (to the extent possible) with Molina Healthcare and your providers so that they can give you appropriate care.
6. Understand your health conditions (to the degree possible) and be active in decisions about your health care.
7. Work with your provider to develop treatment goals and follow the care plan that you and your provider have developed.
8. Ask questions if you do not understand your benefits.
9. Call Molina Healthcare within 24 hours of a visit to the emergency department or an unexpected stay in the hospital.
10. Inform Molina Healthcare if you would like to change your PCP. Molina Healthcare will verify that the PCP you select is contracted with Molina Healthcare and is accepting new patients.
11. Inform Molina Healthcare and your county caseworker if you change your name, address or telephone number or if you have any changes that could affect your eligibility.
12. Let Molina Healthcare and your health care providers know if you or any of the members of your family have other health insurance coverage.
13. Report any fraud or wrongdoing to Molina Healthcare or the proper authorities.

#### **D. Open Access Health Care Services**

Members must receive services covered by Molina Healthcare from facilities and/or providers on Molina Healthcare's panel. Members may use providers that are not on Molina Healthcare's panel for the following services:

- Federally qualified health centers/rural health clinics
- Qualified family planning providers
- Community mental health centers
- Ohio Department of Mental Health and Addiction Services (ODMHAS) facilities which are Medicaid providers

In addition, Molina Dual Options members have the right to:

- Request a State Fair Hearing by calling (800) 952-5253. Members also have the right to receive information on the reason for which an expedited State Fair Hearing is possible.
- Receive family planning services, treatment for any sexually transmitted disease and emergency care services from Federally Qualified Health Centers and/or Indian Health Services without receiving prior approval and authorization from Molina Healthcare.

#### **E. Women's Health**

Ohio regulations require that women be permitted direct access to contracted women's health care providers without a referral or prior authorization. Women's health services must be obtained from a Molina Healthcare network provider or a Qualified Family Planning Provider (QFPP). Members may seek direct care from any

participating women's health care provider or QFP for any of the following types of service:

- Maternity
- Gynecological
- Preventive care
- Other health problems discovered and treated during the course of the visit which are within the provider's scope of practice

## **X. Appeals and Grievances**

### **A. Appeals, Grievances, and State Hearings**

Molina Healthcare maintains an organized and thorough grievance and appeal process to ensure timely, fair, unbiased, and appropriate resolutions. Molina Healthcare members, or their authorized representatives, have the right to voice a grievance or submit an appeal through a formal process.

Molina Healthcare ensures that members have access to the appeal process, by providing assistance throughout the whole procedure in a culturally and linguistically appropriate manner; including oral, written, and language assistance if needed. Grievance information is also included in the Member Handbook.

This section addresses the identification, review, and resolution of member grievances and appeals.

### **B. MEMBER APPEALS AND GRIEVANCES**

The Ohio Administrative Code defines a grievance (complaint) as an expression of dissatisfaction with any aspect of Molina Healthcare or participating providers' operations, provision of health care services, activities or behaviors.

Members may file a grievance by calling Molina Healthcare's Member Services department at:

- Medicaid: (800) 642-4168 (TTY/Ohio Relay (800) 750-0750 or 711), Monday through Friday from 7 a.m. to 7 p.m.
- Molina Dual Options (full benefits): (855) 665-4623 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.
- Molina MyCare Ohio Medicaid (opt-out): (855) 687-7862 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.

Members may also submit a grievance in writing to:

Molina Healthcare of Ohio, Inc.  
Attn: Appeals and Grievance Department  
PO Box 349020  
Columbus, Ohio 43234-9020

Members may authorize a designated representative to act on their behalf (hereafter referred to as “representative”). The representative can be a friend, a family member, health care provider, or an attorney. An [Authorized Representative Form](#) can be found on Molina Healthcare’s member website at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com).

Molina Healthcare will investigate, resolve and notify the member or representative of the findings. Every attempt will be made to resolve a grievance at the time of a call. However, if a grievance is unable to be resolved immediately, it will be resolved as expeditiously as possible, but no later than the following time frames:

- Two working days of receipt of a grievance related to accessing medically necessary Medicaid covered services
- Thirty calendar days of receipt for grievances that are not claims related.
- Sixty calendar days for grievances regarding bills or claims

If the grievance resolution affirms the denial, reduction, suspension, or termination of a Medicaid-covered service, or if the resolution permits the billing of a member due to Molina Healthcare’s denial of payment for that service, Molina Healthcare will notify the member of his or her right to request a state hearing.

All grievances received will be kept confidential except as needed to resolve the issue and respond to the member or representative.

An appeal is the request for a review of an action. The member or his or her representative acting on the member’s behalf has the right to appeal Molina Healthcare’s decision to deny a service. For member appeals, Molina Healthcare must have written consent from the member authorizing someone else to represent him or her. A determination will not be made if written consent is not received within 15 days from the date the appeal was received. An [Authorized Representative Form](#) can be found on Molina Healthcare’s member website at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com). An appeal can be filed verbally or in writing within 90 days from the date of the Notice of Action. Molina Healthcare will send a written acknowledgement in response to written appeal requests received. Molina Healthcare will respond to the member or representative in writing with a decision within 15 days (unless an extension is granted to Molina Healthcare by ODM).

While lack of written consent does not pose any barrier to the commencement of the appeal process, if it is not received within the time frame, the appeal request will be closed and no determination will be made.

The member or representative should state the reason he or she feels the service should be approved and be prepared to provide any additional information for review. For a copy of the Grievance and Appeal Form, see the [Forms](#) section of this manual.

Molina Healthcare has an expedited process for reviewing member appeals when the standard resolution time frame could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function.

Expedited member appeals may be requested by the member or representative orally or in writing. Molina Healthcare will inform the member or representative of the decision to treat the appeal as expedited within 24 hours of receipt. With few exceptions, an expedited member appeal will be resolved as expeditiously as the member's health condition requires, but will not exceed 72 hours from receipt and the member or representative will be notified. No punitive action will be taken against a member or representative for filing an expedited member appeal.

If Molina Healthcare denies the request for an expedited resolution of an appeal, the appeal will be treated as a standard appeal and resolved within 15 calendar days from the receipt date (unless an extension was granted).

A member has the right to request a state hearing from the Bureau of State Hearings any time there is dissatisfaction with Molina Healthcare's decision. It is not necessary for a member or representative to file an appeal prior to requesting a state hearing.

Members are notified of their right to a state hearing in all of the following situations:

- A service denial (in whole or in part)
- Reduction, suspension or termination of a previously authorized service
- A member is being billed by a provider due to a denial of payment and Molina Healthcare upholds the decision to deny payment to the provider

A health care provider may act as the member's authorized representative or as a witness for the member at the hearing.

Appeal decisions not wholly resolved in the member's favor will include information on how to request a state hearing and instructions on how to continue receiving benefits if benefits were denied until the time the state hearing is scheduled. If the state hearing upholds Molina Healthcare's decision, and continued benefits were requested in the interim, the member may be responsible for payment.

## XI. Provider Responsibilities

### A. NON DISCRIMINATION

Participating providers cannot discriminate against any member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, place of residence, socioeconomic status or status as a recipient of Medicaid benefits. Additionally, participating providers or contracted medical groups/IPAs may not limit access to the practice because of a member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.

### B. CHILD ABUSE AND NEGLECT

Under Ohio law, providers are mandated to report any suspicion of child abuse or neglect to local children services agencies or law enforcement agencies. Providers should be knowledgeable in recognizing cases of child abuse and neglect and the proper methods of handling evaluation and referral.

### C. ACCESS TO CARE STANDARDS

#### **Molina Healthcare Appointment and Availability Standards:**

Primary care appointment and availability standards are a derivative of NCQA standards as described in QI 5, Element A; HEDIS<sup>®</sup>/CAHPS<sup>®</sup> 4.0H Survey and member complaints, site-specific surveys regarding access to offices of practitioners providing primary care and monitoring of member access grievance data. NCQA describes types of care to measure and the other data sources are used to develop standards.

Non-primary care appointment and availability standards are a derivative of site-specific surveys regarding access to offices of practitioners providing non-primary care service and monitoring of member access grievance data. NCQA does not define types of care or access standards for non-primary care. Therefore, types of care and service standards are based on the information described above along with Molina Healthcare adopted industry standards.

Behavioral health appointment and availability standards are a derivative of NCQA standards as described in QI 5, Element B, member surveys, and self-reported access data from practitioners supplemented with an analysis of member access grievance data. NCQA describes types of care to measure and the access standard.

Category	Type of Care	Access Standard
<b>PCP (general practitioners, internist, family practitioners, pediatricians)</b>	Preventive/routine care	Within six weeks
	Urgent care	By the end of the following work day
	Emergent care	Triaged and treated immediately

	After hours	Available by phone 24 hours a day, seven days a week
<b>OB/GYN</b>	Pregnancy (initial visit)	Within two weeks
	Routine visit	Within six weeks
<b>Orthopedist</b>	Routine visit	Within eight weeks
<b>Otolaryngologist (ENT)</b>	Routine visit	Within six weeks
<b>Dermatologist</b>	Routine visit	Within eight weeks
<b>Dental</b>	Routine visit	Within six weeks
<b>Endocrinologist</b>	Routine visit	Within eight weeks
<b>Allergist</b>	Routine visit	Within eight weeks
<b>Neurologist</b>	Routine visit	Within eight weeks
<b>Behavioral health</b>	Routine care	Within 10 business days
	Urgent care	Within 48 hours
	Non-life threatening emergency	Within six hours
<b>All other non-primary care</b>	Routine care	Within eight weeks
<b>All</b>	Office wait time	Maximum of 30 minutes

Access to care standards are reviewed by the Molina Healthcare Executive Quality Improvement Committee.

Molina Healthcare conducts an annual survey to measure compliance with Molina Healthcare's published access to care standards and performs targeted education and/or implements corrective action plans with those participating providers not meeting the standards.

#### **D. PRIMARY CARE PROVIDER RESPONSIBILITIES**

PCPs are responsible to:

- Serve as the ongoing source of primary and preventive care



- Assist with coordination of care as appropriate for the member's health care needs
- Recommend referrals to specialists participating with Molina Healthcare
- Triage appropriately
- Notify Molina Healthcare of members who may benefit from Care Management
- Participate in the development of Care Management treatment plans

#### **E. ADVANCE DIRECTIVES**

Under Ohio law, there are three types of advance directives:

- Living Will – Allows patients to put wishes about medical care in writing for situations when they are unable to make these wishes known
- Declaration for Mental Health Treatment – Allows patients to appoint a proxy to make decisions specifically about mental health treatment on their behalf when they lack the capacity to make these decisions
- Durable Power of Attorney – Allows patients to choose a representative to carry out their wishes regarding medical care when they cannot act for themselves

Providers must discuss with patients their right to make health care decisions and execute Advance Directives, and provide appropriate medical advice if requested. Providers must document the presence of Advance Directives in a prominent location in the patient's medical record.

Providers must honor Advance Directives to the fullest extent of the law. In no event may a provider refuse to treat a patient or otherwise discriminate against a patient because the patient has completed an Advance Directive. However, Ohio law includes a conscience clause. If a provider cannot follow an Advance Directive because it goes against conscience, they must assist the patient in finding another provider who will carry out the patient's wishes. Under Ohio law, patients have the right to file a complaint related to Advance Directives with the Ohio Department of Health.

Molina Healthcare does random audits of providers' medical records to ensure the integrity and quality of medical record keeping. Auditors check patient medical records for documentation of Advance Directives discussions and for forms that are complete and on file. Lack of Advance Directives documentation in medical records may result in corrective action being taken against the provider.

#### **F. OFFICE SITE STANDARDS**

All providers are expected to comply with the office site standards listed below.

##### ***Facilities***

Facilities are reviewed for accessibility and safety, including:

- Parking area and walkways demonstrate appropriate maintenance.
- Office appearance demonstrates that housekeeping and maintenance are performed.
- The parking area is reasonably accessible and has adequate handicapped parking available.

- The building and exam rooms are accessible with wide doorways and incline ramp or flat entryway.
- The restroom is handicapped accessible with wide doorways and bathroom grab bars.
- Waiting area has adequate seating, lighting and space for an average number of patients in an hour.
- Labeled containers, policies, and provides evidence of contracts or alternative appropriate method of hazardous waste management.
- A container for sharps is located in each room where injections are given.
- Fire extinguishers are checked annually with tags showing review dates.
- Available crash carts/kits are checked monthly and initials document the review.
- Basic emergency equipment is located in an easily accessible area. This includes epinephrine, plus any other medications or equipment appropriate to the practice.
- At least one CPR-certified staff member is on duty when patients are present.
- Exit signs are clearly visible.
- Evacuation routes are posted in a visible location.
- Disclosure of privacy practices is posted to comply with HIPAA regulations.

### ***Member Accessibility***

Appointment schedules and policies and procedures are reviewed to evaluate how the provider meets the accessibility standards:

- Standards for appointments and wait times comply with those listed above.
- After hours coverage is available through the provider or another participating provider.
- Hours of operation for Molina Healthcare members are no less than those offered to commercially-insured members.

### ***Administration***

The following areas are evaluated through review of policies and procedures, interviews with staff, inspection of equipment and cabinets, observation of patient flow (when practical) and review of appropriate documentation.

- A current CLIA waiver is in place when the appropriate lab work is run in the office.
- X-ray certificate and maintenance records are posted in the department.
- Radiology operator licenses are posted in the department.
- Prescription pads are not kept in the exam rooms.
- All prescription medications, needles and syringes are isolated from patient areas and preferably locked.
- Narcotics are inaccessible to patients.
- All drugs, including samples and emergency medications, are checked monthly for outdates and documented.
- Drug refrigerator and freezer temperatures are documented daily if applicable to practice.
- Patient check-in systems provide for confidentiality.
- Medical records are inaccessible to patients.

## **G. Medical Record Keeping and Documentation**

A confidential medical record must be maintained for each member that includes all pertinent information regarding medical services rendered. Providers must maintain established standards for accurate medical record keeping. The following categories are reviewed during onsite office visits:

- Medical records are secured from patient and public access and are restricted to identified staff
- Medical record release procedures are compliant with state and federal regulations
- Patient records are available for each encounter
- There is an individual record for each patient
- Forms and methodology for filing within a chart is consistent
- Allergies and reactions or No Known Allergies (NKA) are clearly indicated on each chart
- Discussion about Advance Directives is documented for patients 18 and older
- The patient's name appears on each sheet in chart
- There is a date and signature or initial on each entry/report in chart
- There is a procedure for documenting MD review and patient notification prior to filing lab, x-ray, and other reports in chart
- There is a procedure for documenting patient phone communications

In addition, complete medical record reviews may be conducted to support Molina Healthcare's Quality Improvement program. Providers must demonstrate 80 percent overall compliance in medical record documentation. Molina Healthcare uses the guidelines below when evaluating medical record documentation.

A completed problem list is in a prominent space. Any absence of chronic/significant problems must be noted. Allergies are listed on the front cover of the record or prominently in the inside front page. If the patient has no known allergies, this is appropriately noted.

- A complete medical history is easily identified for patients seen three or more times. For children under 7 years of age, this includes source of history, family medical history, family social history, prenatal care and summary of birth events, developmental history, allergies, medication history, lead exposure, tobacco exposure, safety practices, serious accidents, operations and illnesses.
- A working diagnosis is recorded with the clinical findings. Subjective Objective Assessment Plan (SOAP) charting is recommended but not mandatory when progress notes are written.
- The plan of action and treatment is documented for the diagnosis.
- There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
- Patient name and identifying number is on each page of the record.

- The registration form or computer printout contains address, home, and work phone numbers, employer, gender and marital status. An emergency contact should also be designated.
- All staff and provider notes are signed with initials or first initial, last name and title.
- All entries are dated.
- The record is legible to someone in the office other than the provider. Dictation is preferred.
- There is an appropriate notation concerning tobacco exposure for children of all ages and the use of alcohol, tobacco, and substance abuse for patients 12 years old and older. Query history of the abuse by the time the patient has been seen three or more times.
- Pertinent history for presenting problem is included.
- Record of pertinent physical exam for the presenting problem is included.
- Lab and other studies are ordered as appropriate.
- There are notations regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or as needed. Include the preventive care visit when appropriate.
- Previous unresolved problems are addressed in subsequent visits.
- Evidence of appropriate use of consultants. This is reviewed for under and over utilization.
- Notes from consultants are included in the record.
- All reports show initials of provider who ordered them.
- All consult and abnormal lab/imaging results show explicit follow-up plans.
- There is documentation of appropriate health promotion and disease prevention education.
- Anticipatory guidance is documented at each well child check.
- An immunization record and appropriate history of immunization has been made for both children and adults.
- Preventive services are appropriately used/offered in accordance with accepted practice guidelines.
- All patients 18 years of age and older should be evaluated for evidence of Advance Directives and the medical record should reflect documentation of such.

#### Medical Record Organization

- The medical record is legible to someone other than the writer.
- Each patient has an individual medical record.
- Chart pages are bound, clipped or attached to the file (N/A for electronic files).
- Chart selections are easily recognized for retrieval of information (i.e. sections are labeled lab, consults, progress notes, etc.).

#### Medical Record Retrieval

- The medical record is available to the provider at each patient encounter.

- The medical record is available to Molina Healthcare for quality improvement purposes.
- Medical record retention is at least 8 years per OAC 5160-26-6 and 5160-26-05.
- Data recovery process is in place in the event of data loss (i.e., fire, vandalism, etc.).

Please remember the following about the medical record:

- It is a medical record that must be treated confidentially, as defined by HIPAA regulations.
- It is a legal document you may have to defend in court much later, after your memory has faded.
- It is a historical record of the event from which a bill of service will be generated.

## **H. MEDICAL RECORD CONFIDENTIALITY**

Molina Healthcare members have the right to privacy concerning their medical care. They are also entitled to confidential treatment of all member communications and records. Case discussion, consultation, examination, and treatments are confidential and should be conducted with discretion. Written authorization from the member or his/her authorized legal representative must be obtained before medical records are released to anyone not directly connected with his/her care, except as permitted or required by law.

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

All participating providers must implement and maintain an office procedure that will guard against disclosure of any confidential information to unauthorized persons. This procedure should include:

- Written authorization obtained from the member or his/her legal representative before medical records are made available to anyone not directly connected with his/her care, except as permitted or required by law.
- All signed authorizations for release of medical information received must be carefully reviewed for any limitations to the release of medical information.
- Only the portion of the medical record specified in the authorization should be made available to the requestor and should be separated from the remainder of the member's medical records.
- ODJFS Form 03397 Authorization for Release of Protected Health Information and 01952 Request for Amendment to Protected Health Information, 01953 Request for Restriction of Use or Disclosure of Protected Health Information (PHI) should be used when appropriate.

## **I. MEMBER INFORMATION AND MARKETING**

Any written informational and marketing materials directed at Molina Healthcare members must be developed in a manner that is easily understandable and must have prior written consent from Molina Healthcare. Please contact your Provider Relations Representative for information and review of proposed materials.

Neither Molina Healthcare, nor any of its contracted providers or medical groups may:

- Distribute to its members informational or marketing materials that contain false or misleading information.
- Distribute to its members marketing materials selectively within the service area.
- Directly or indirectly conduct door-to-door, telephonic, or other cold-call marketing for member enrollment.

#### **J. NOTIFICATION OF CHANGES**

It is important that offices notify Molina Healthcare of any changes in the practice that impact the membership, including change of address, phone or fax number, addition of new practitioners, practitioners leaving the practice or closing the panel to new members. These changes must be submitted to Molina Healthcare as soon as possible to minimize claims issues, care, and service to our members. Written correspondence is required and must be submitted on the appropriate form(s).

#### **K. PROVIDER PANEL**

If a PCP chooses to close his or her panel to new members, Molina Healthcare must receive 30 days advance notice from the provider. Written correspondence is required and must include the reason and the effective date of the closure. If the panel will not be closed indefinitely, correspondence should also include the re-open date.

If a reopen date for the panel is not known, a letter will need to be submitted when the office is ready to reopen the panel to new patients.

#### **L. GUIDE TO FORMS**

If you need to add, term or change information, submit Molina Healthcare's [Provider Information Update Form](#) available at [www.MolinaHealthcare.com/Providers/OH](http://www.MolinaHealthcare.com/Providers/OH) under the "Forms" tab.

#### **M. INTERPRETER SERVICES**

##### **Members with Limited English Proficiency (LEP), Limited Reading Proficiency (LRP), or Limited Hearing or Sight**

Molina Healthcare is dedicated to serving the needs of our members and has made arrangements to ensure that all members have information about their health care provided to them in a manner they can understand.

All Molina Healthcare providers are required to comply with Title VI of the Civil Rights Act of 1964 in the provision of covered services to members. Compliance with this provision includes providing interpretation and translation services for members requiring such services, including members with LEP. Written procedures are to be

maintained by each office or facility regarding their process for obtaining such services. Documentation of such services shall be kept in the member's chart.

### **Arranging for Interpreter Services**

If a member has LEP, the provider may call Member Services for assistance with locating translation services. If a member requires an on-site interpreter for sign language or foreign interpretation, the provider may call Provider Services to request assistance with locating interpreter services.

Pursuant to Title VI of the Civil Rights Act of 1964, services provided for members with LEP, LRP, or limited hearing or sight are the responsibility of the provider. Under no circumstances are Molina Healthcare's members responsible for the cost of such services.

- If a member cannot hear or has limited hearing ability, use the Ohio Relay Service/TTY at (800) 750-0750 or 711.
- If a member has limited or no vision, documents in large print, Braille or audio can be obtained by calling Member Services.
- If a member has LRP, contact Member Services. The representatives will verbally explain the information, up to and including reading the document to the member, or provide the documents in audio version.

### **Provider Guidelines for Accessing Interpreter Services**

When Molina Healthcare members need interpreter services for health care services the provider should:

- Verify member's eligibility and medical benefits.
- Inform the member that interpreter services are available.
- Contact Molina Healthcare immediately if assistance in locating interpreter services is needed.

## **N. PREGNANT MEMBERS**

- Molina Healthcare contracted providers should notify the Molina Healthcare Utilization Management department when providing care to pregnant members. This notification helps Molina Healthcare identify members who may need to be monitored for high-risk pregnancies.
- Providers must also include the Last Menstrual Period (LMP) date in field 14 of the CMS 1500 claim form for pregnant members.
- Hospitals are required to notify Molina Healthcare within 24 hours or the first business day of any inpatient admissions, including deliveries, in order for hospital services to be covered.

## **XII. Provider Portal**

Molina Healthcare providers may register on the [Provider Portal](#) at <http://Provider.MolinaHealthcare.com> to verify member eligibility and benefits, submit or search for service requests/authorizations, submit or view claims status, and other helpful information.

**Enhanced Security** – Online access is more secure than phone or fax so providers are encouraged to communicate with Molina Healthcare online. The provider registration process includes a how-to video that guides providers on the Provider Portal registration process. Providers may add additional users to their accounts. The level of access to information can be better controlled online, further improving information security.

**Claims Status and Submissions** – In the Provider Portal, providers can submit claims, view claim status updates, and receive status change notifications. Claims information is updated daily so providers will know sooner if a claim is paid or denied. Messaging capabilities automatically notify providers of claims and service request/authorization status changes. Providers can also submit claims in batch, create claims templates, submit corrected claims and void claim submissions.

**Service Request/Authorization Enhancements** – Providers are able to apply templates to requests they frequently use, copy information from previous requests, and attach documentation and clinical notes, reducing the time it takes to prepare and submit requests. Providers are also able to view service requests/authorizations for their patients/Molina Healthcare members and will receive notifications when they create a service request/authorization to determine if a patient/Molina Healthcare member previously received the service.

**Member Eligibility** – Providers can access their member eligibility details with a Quick View bar that summarizes the member's eligibility at a glance. Additional member details include HEDIS<sup>®</sup> missed services, benefit summary of covered services and access to member handbooks.

**Member Roster** – The Provider Portal offers a flexible Member Roster tool to help make member management easier for providers. The feature provides the ability to view an up-to-date member list and customize member searches with built-in filters. Providers can view various statuses for multiple members – such as new members, inpatients who are or will be in a hospital, and if any member has missing services through HEDIS<sup>®</sup> alerts. This feature also acts as a hub to access other applications within the Provider Portal such as Claims, Member Eligibility, and Service Request/Authorizations.

**HEDIS<sup>®</sup> Scorecard** – The Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>) Scorecard measures the performance of care and needed services conducted by a provider. The HEDIS<sup>®</sup> data is specifically measured so that the scores can be compared amongst various health plans. This feature emphasizes the quality aspect to our providers and members. The HEDIS<sup>®</sup> Scorecard also allows HEDIS<sup>®</sup> submissions to be electronic and automated, making delivery of documentation to the Molina Healthcare HEDIS<sup>®</sup> and Quality Department quicker and more efficient.



### XIII. Appendix A

#### Medicaid Benefits Index

All covered services must be medically necessary. Some are subject to prior authorization (PA) requirements and limitations. All services rendered by non-participating providers, excluding emergency and urgent care, require PA. Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility, benefit limitation/exclusions, evidence of medical necessity during the claim review, and provider status with Molina Healthcare of Ohio.

If more information is needed, contact Molina Healthcare Provider Services at (855) 322-4079.

Services	Benefit Coverage Information	Additional Information
Abortion	Not covered, except when medically necessary to save the life of the mother or in instances of reported rape or incest.	PA required. <a href="#">Abortion Certification Form</a> (JFS 03197) required, available online at <a href="http://www.MolinaHealthcare.com">www.MolinaHealthcare.com</a> .
Acupuncture	Not covered.	
Alcoholism Treatment	<p>Molina Healthcare will cover inpatient or outpatient treatment for medical conditions resulting from or associated with alcoholism or chemical dependency.</p> <p>Members may obtain services through Ohio Department of Mental Health and Addiction Services (ODMHAS)-certified Medicaid providers or from network providers.</p> <p>Coverage is provided through network providers for members who are unable to timely access services or are unwilling to access services through ODMHAS providers.</p> <p>Molina Healthcare covers:</p> <ul style="list-style-type: none"> <li>• Alcohol and other drug (AOD) urinalysis screening</li> <li>• Assessment</li> <li>• Counseling</li> <li>• Physician/psychologist/ psychiatrist AOD services</li> <li>• Outpatient hospital and clinic AOD treatment services</li> <li>• Crisis intervention</li> <li>• Inpatient detoxification services in a general hospital</li> </ul>	<p>Medical-related inpatient services require PA.</p> <p>No authorization required for non-medical treatment or counseling if obtained at ODMHAS facilities.</p> <p>All outpatient services require PA (driven by diagnosis codes).</p>

Services	Benefit Coverage Information	Additional Information
	<ul style="list-style-type: none"> <li>AOD related laboratory services</li> </ul> Outpatient detoxification and methadone maintenance are not covered.	
Ambulance and Wheel chair Services	Covered.	Effective Jan. 1, 2014 PA is required for non-emergent services.
Antigen (Allergy Serum)	Covered.	
Attention Deficit Disorder (ADD)	If treated by PCP, pediatrician or neurologist, covered as a medical condition.  If treated by a psychiatrist or other Mental Health (MH) professional see Behavioral Health below.	
Behavioral Health	Members may self-refer to Community Mental Health Centers or ODMHAS facilities for services.  Members may be seen by network behavioral health providers up to 12 office visits for adults ages 21 and older and 20 visits for children ages 0 to 20 in a calendar year without PA.	No PA is required for self-referrals.  PA required for additional office visits.
Biofeedback	Not covered.	
Birth Control	Oral contraceptive drugs are covered by Ohio Medicaid.  Certain contraceptive devices and injections are covered by Molina Healthcare.	No PA required.
Birthing Centers	Covered.	
Blood Products	Covered services include blood, blood components, human blood products and their administration.	
Braces (Orthodontics)	Covered for children under the age of 20 and subject to medical review and limitations.  If prior authorized and started by another provider, services related to the braces are covered through the end of the period initially authorized for the braces.	PA required. Contact Scion Dental
Braces (Orthopedic)	Covered. Replacement subject to medical review and limitations.	See Molina Healthcare's <a href="#">codified PA list</a> available at <a href="http://www.MolinaHealthcare.com">www.MolinaHealthcare.com</a> .
Breast Implants	Breast implants for cosmetic purposes are not	PA required.

Services	Benefit Coverage Information	Additional Information
	covered.  Breast implants deemed medically necessary for medical complications are covered. See Reconstructive Surgery.	
Breast Implant Removal	Breast implant removal for cosmetic purposes is not covered.  Breast implant removal deemed medically necessary as a result of medical complications is covered.	PA required.
Breast Reductions	Breast reductions for cosmetic purposes are not covered. Breast reduction deemed medically necessary as a result of medical complications is covered.	PA required.
Cardiac Rehab	Covered only after a cardiac event.	PA required
Chemical Dependency	Inpatient or outpatient treatments for medical conditions resulting from or associated with alcoholism or chemical dependency are covered.  Members may self-refer to obtain services through ODMHAS-certified Medicaid providers.  Members may be seen by network behavioral health providers with PA.	Medical-related inpatient services require PA.  No authorization required for non-medical treatment or counseling if obtained at ODMHAS facilities.
Chemotherapy	Covered.  Experimental or investigational treatment is not covered.	No PA required. Some exclusions apply. See Molina Healthcare's <a href="#">codified PA list</a> available at <a href="http://www.MolinaHealthcare.com">www.MolinaHealthcare.com</a> .
Chiropractic Care	Spinal manipulative therapies only; must be associated with an acute injury.	
Circumcision	Newborn: Covered.  Adults: Covered if medically necessary.	Adult circumcision requires PA.
Contact Lenses	Not covered for routine vision correction.  Covered when medically necessary due to loss of lens (aphakia).	
Counseling	See <a href="#">Behavioral Health</a> .	
Court Ordered Treatment	Not covered.	
Custodial Care	Generally not covered.	

Services	Benefit Coverage Information	Additional Information
Dental Care	<p>Cleaning/checkup once every 12 months is covered for adults and once every six months for children.</p> <p><b>Effective Jan. 1, 2017 for Medicaid members – Cleaning/checkup once every 6 months is covered for adults and children.</b></p> <p>Removal of impacted wisdom teeth and emergency tooth re-implantation for adults is covered.</p> <p>Dentures, partial plates and braces require PA and are subject to medical review and limitations. Dentures and plates may be replaced every eight years.</p> <p>For specific coverage information regarding extraction, restorative services and medical services related to dental care, contact Provider Services.</p>	PA required for non-routine services. Contact Scion Dental.
Diabetes Education	Covered.	
Diabetic Supplies	Covered.	Pharmacy benefit.
Dialysis	Hemodialysis or other appropriate procedures or treatment of renal failure including equipment are covered.	Notification is required.
Diapers	Diapers are covered if medically necessary for enrollees age 3 and older.	No PA required for 200 per month/2,400 per year.
Durable Medical Equipment (DME)	<p>Certain DME are covered by Ohio Medicaid. Prosthetic and orthotic devices, orthopedic appliances and braces, breast pumps, selected medical supplies, oxygen and related equipment are covered.</p> <p>Incontinence supplies (other than diapers) are covered for enrollees older than 3 years of age.</p> <p>Shoe inserts are not covered.</p> <p>See the Medicaid Supply List at <a href="http://emanuals.odjfs.state.oh.us/emanuals/DataImages.srv/emanuals/pdf/pdf_forms/">http://emanuals.odjfs.state.oh.us/emanuals/DataImages.srv/emanuals/pdf/pdf_forms/</a></p>	See Molina Healthcare's <a href="#">codified PA list</a> available at <a href="http://www.MolinaHealthcare.com">www.MolinaHealthcare.com</a> .

Services	Benefit Coverage Information	Additional Information
	<a href="#">OAC5160_10_03_APPXA.PDF</a> and <a href="#">OAC 5160-10-20 Appendix A, List of Orthotic and Prosthetic Procedures.</a>	
Eating Disorders	<p>Medically-necessary treatment of eating disorders such as bulimia and anorexia nervosa are covered.</p> <p>Also see <a href="#">Behavioral Health</a>, <a href="#">Obesity</a> and/or <a href="#">Weight Loss</a>. Members may be seen by network behavioral health providers up to 12 office visits for adults ages 21 and older and 20 visits for children ages 0 to 20 in a calendar year without PA.</p>	<p>PA is not required if obtained through Community Mental Health Centers (CMHCs).</p> <p>PA required for additional office visits.</p>
Emergency Department Services	<p>Emergencies and urgent care are covered.</p> <p>When a consumer moves or is temporarily staying outside the service area, coverage shall be limited to emergent and urgent care, including unplanned labor and delivery out of area.</p>	Must contact Molina Healthcare within 24 hours or the next business day for all admissions.
Experimental Treatment or Devices	Not covered.	
Fertility Drugs	Not covered.	
Formula/Enteral Feeding	<p>Covered if prescribed by a physician and determined to be medically necessary.</p> <p>Standard infant formula not covered. Refer consumer to Women, Infants and Children (WIC) program for assistance with infant formula.</p>	PA required.
Gastroplasty	Gastroplasty, gastric stapling or ileo-jejunal shunt are covered only for morbid obesity when certain medical complications or conditions are present following ODM guidelines.	PA required.
Genetic Testing	Genetic testing to evaluate the risk of familial disease or inherited disorder is covered. Paternity testing and forensic testing is not covered.	PA required if diagnosis is not related to pregnancy.
Glucometers and related supplies	Covered.	Pharmacy benefit.
Health Education	Health education and nutritional counseling for specific conditions such as diabetes, high blood pressure and anemia are covered.	Must be obtained from network providers.

Services	Benefit Coverage Information	Additional Information
	Education by the PCP as part of Healthchek EPSDT for children is also covered.	
Hearing Aids	Covered. Must meet specific criteria and is limited to one hearing aid per four years for adults. Hearing aids are covered as medically necessary for children.	PA required.
Home Health Aide	Covered when medically necessary.	PA required.
Home Health Care	Skilled home health services are covered when provided through network agencies. The first three visits do not require a PA, however a certificate of medical necessity (CMN) is required to be on file with the provider.	PA required. A face-to-face encounter 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 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 PA, provided the appropriate diagnosis code(s) are billed on the claim(s).	No PA required.
Hospice & Palliative Care	Covered when provided through network agencies for consumers with life expectancy of less than six months.	Notification is required.
Hospitalization	Covered.  Consumers scheduled for elective procedures must be admitted to network facilities (unless the service cannot be safely performed in a network facility and is approved in advance by Molina Healthcare).	PA required for elective and non-emergent admissions.
Hysterectomy	<a href="#">Consent to Hysterectomy Form</a> required except in unique circumstances of an unscheduled clinical event that requires a hysterectomy because of a life-threatening emergency.  See <a href="#">OAC 5160-21-02.2 Medicaid Covered Reproductive Health Services: Permanent Contraception/Sterilization Services and Hysterectomy</a> .	PA required. <a href="#">Consent to Hysterectomy Form</a> (JFS 03199) required, available online at <a href="http://www.MolinaHealthcare.com">www.MolinaHealthcare.com</a> .
Immunizations	Routine immunizations (those included in the Vaccines for Children) are covered.  Immunizations required for travel outside the United States are not covered.	See <a href="#">OAC 5160-4-12 Immunizations, Injections and Infusions (Including Trigger-Point Injections), and Provider-Administered Pharmaceuticals</a> .

Services	Benefit Coverage Information	Additional Information
Impotence Treatment	Not covered.	
Incarcerated Members	<p>Services provided to members while incarcerated are generally not covered.</p> <p>If incarcerated more than 15 days, the consumer is disenrolled from Molina Healthcare.</p>	
Infertility Testing and Treatment	Not covered.	
Learning Disorders	<p>See <a href="#">Neuro-developmental Therapy</a>.</p> <p>Refer to <a href="#">Bureau for Children with Medical Handicaps</a>.</p>	
Mammogram	<p>Covered for women 35 years of age or older, unless a woman is at high-risk of developing breast cancer.</p> <p>One screening mammography for women 34 to 40 years of age.</p> <p>One screening mammography every 12 months may be paid for a Molina Healthcare member who is over the age of 39.</p> <p>Mammography's provided for the diagnosis and treatment of women who show clinical symptoms indicative of breast cancer are covered regardless of the recipient's age.</p>	See <a href="#">OAC 5160-4-25 Laboratory and Radiology Services</a> .
Massage Therapy	Not covered.	
Maternity Care	<p>Covered through Community Mental Health Centers (CMHCs).</p> <p>Coverage provided through network providers for members who are unable to timely access services or are unwilling to access services through community providers of Behavioral Health Services.</p> <p>Molina Healthcare covers and ensures access to:</p> <ul style="list-style-type: none"> <li>• Diagnostic assessment/clinical evaluation</li> <li>• Counseling and psychotherapy</li> <li>• Physician/psychologist/ psychiatrist services</li> </ul>	<p>No authorization required if obtained at CMHCs.</p> <p>Members may be seen by network behavioral health providers up to 12 office visits for adults ages 21 and older and 20 visits for children ages 0 to 20 in a calendar year without PA. PA is required for additional office visits.</p>

Services	Benefit Coverage Information	Additional Information
	<ul style="list-style-type: none"> <li>• Outpatient hospital and clinic services</li> <li>• Crisis intervention</li> <li>• Behavioral health related laboratory services</li> </ul> <p>The following services are not covered:</p> <ul style="list-style-type: none"> <li>• Sexual or marriage counseling</li> <li>• Services provided in a facility regulated by the Board of Education</li> <li>• Sensitivity training, encounter groups or workshops</li> <li>• Sexual competency training</li> <li>• Marathons and retreats for mental disorder</li> <li>• Educational activities, testing and diagnosis</li> <li>• Monitoring activities of daily living</li> <li>• Recreational therapy (e.g., art, play, dance or music)</li> <li>• Partial hospitalization is not covered</li> <li>• Teaching grooming skills</li> <li>• Services primarily for social interaction, diversion, or sensory stimulation</li> <li>• Psychotherapy services are not covered if the patient's cognitive deficit is too severe to establish a relationship with the psychotherapist</li> <li>• Inpatient psychiatric care in a free standing psychiatric hospital</li> </ul>	
Military Service Related Disabilities	<p>Services provided through network providers are covered.</p> <p>Care obtained at Veterans Administration facilities is covered through the Veterans Administration Program.</p>	PA required.
Naturopathy	Not covered.	
Neuro-developmental Therapy	<p>Covered by plan under the therapy benefit if obtained through participating provider. Medical review and limitations apply. Member must show continued improvement in order to be considered medically appropriate.</p>	PA required.
Norplant-Implantable Contraceptives	<p>U.S. Food and Drug Administration (FDA)-approved implantable contraceptives are covered.</p>	
Nursing Homes	See <a href="#">Skilled Nursing Facilities</a> .	
Nutritional	Nutritional counseling is covered for specific	Commercial weight loss



Services	Benefit Coverage Information	Additional Information
Counseling	<p>conditions such as diabetes, high blood pressure and anemia.</p> <p>Counseling by dieticians is covered for children with growth disorders, metabolic diseases and inadequate dietary intake per Healthchek EPSDT guidelines.</p>	<p>programs (such as Weight Watchers, Jenny Craig) are not covered.</p>
Obesity Treatment  (See also <a href="#">Gastroplasty</a> or <a href="#">Weight Loss</a> )	<p>Gastric bypass surgery is covered at a participating inpatient Molina Healthcare facility when certain medical complications/conditions are present following ODM guidelines.</p> <p>Gastroplasty, gastric stapling, or ileo-jejunal shunt could be deemed medically necessary if medical complications or conditions, in addition to the obesity, are present.</p> <p>Counseling by dieticians for the following are covered: children with growth disorders, metabolic diseases and inadequate dietary intake per Healthchek EPSDT guidelines.</p>	<p>PA required. Subject to medical review. Commercial weight loss programs (such as Weight Watchers, Jenny Craig) are not covered.</p>
Observation Services	<p>Services performed in conjunction with outpatient observation services.</p>	<p>PA is not required.</p>
Occupational Therapy  (See also <a href="#">Neuro-developmental Therapy</a> )	<p>Medically necessary therapy for restoration or maintenance of function affected by illness, disability, condition or injury is covered.</p>	<p>PA required.</p>
Oral Surgery	<p>Medical treatments related to oral conditions such as infections, temporomandibular joint (TMJ) disorders, cleft palate, and post-accident surgeries are covered by Molina Healthcare.</p> <p>Oral surgery for cosmetic purposes is not covered.</p>	<p>PA required.</p>
Organ Transplants	<p>Transplants which are medically indicated for specific diagnoses are covered if approved by the Ohio Transplant Consortium.</p> <p>Due to the complexity of transplant coverage decisions, the physician should contact Molina Healthcare Utilization Management for specific</p>	<p>PA required.</p>

Services	Benefit Coverage Information	Additional Information
	information on transplant coverage.	
Orthotics	Covered.  See <a href="#">DME</a> .  Shoe inserts are not covered.	See Molina Healthcare's <a href="#">codified PA list</a> available at <a href="http://www.MolinaHealthcare.com">www.MolinaHealthcare.com</a> .
Out-of-Area Care	When an enrollee moves or is temporarily staying outside the service area, coverage shall be limited to emergent and urgent care, including unplanned labor and delivery.  Emergencies and urgent care are covered within the U.S.	
Outpatient Surgery	Covered.	PA required. Some exclusions apply. See Molina Healthcare's <a href="#">codified PA list</a> available at <a href="http://www.MolinaHealthcare.com">www.MolinaHealthcare.com</a> .
Oxygen	Oxygen, respiratory equipment and supplies are covered.	See Molina Healthcare's <a href="#">codified PA list</a> available at <a href="http://www.MolinaHealthcare.com">www.MolinaHealthcare.com</a> .
Pain Clinics	Covered when medically necessary.	PA required.
Pap Smears	Covered.	
Physical Exams	Routine wellness exams by the PCP, including Healthchek EPSDT exams and annual adult physicals, are covered.	
Physical Therapy  (See also <a href="#">Neuro-developmental Therapy</a> )	Medically-necessary therapy for restoration or maintenance of function affected by illness, disability, condition or injury is covered.	PA required after 30 visits.
Plastic Surgery  (See also <a href="#">Reconstructive Surgery</a> )	Cosmetic procedures are excluded.  Medically necessary reconstructive surgery to correct a functional disorder resulting from a disease state, congenital disease or accidental injury is covered.	PA required.
Podiatry	No limit for peripheral vascular disease and diabetes. Not covered for routine podiatry services.	PA required.
Pre-existing Conditions	No limit for peripheral vascular disease and diabetes. Not covered for routine podiatry services.	PA required.

Services	Benefit Coverage Information	Additional Information
Pre-existing Conditions	Covered, if not specifically excluded.	
Pregnancy and Delivery	Covered.	Notification is required.
Prenatal Care	Covered.	<p>HCPC code H1000 prenatal risk assessment must have form JFS 03535 or Molina Healthcare <a href="#">Prenatal Risk Assessment (PRA) Form</a>, available at <a href="http://www.MolineaHealthcare.com">www.MolineaHealthcare.com</a>, filled out in order to be reimbursed for this service.</p> <p>Coding requirements for a PRA can be found in <a href="#">OAC 5160-21-04 Pregnancy Related Services</a>.</p>
Prescriptions	All medically necessary prescription drugs are covered.	See Molina Healthcare's <a href="#">Preferred Drug List (PDL)</a> for PA requirements, available at <a href="http://www.Molinahealthcare.com">www.Molinahealthcare.com</a> .
Preventive Care	Services are covered according to Molina Healthcare's <a href="#">preventive care guidelines</a> .	
Prostate Testing	Covered according to Molina Healthcare's preventive care guidelines or as needed to diagnose prostate cancer.	
Psychiatric Disorders	See <a href="#">Behavioral Health</a> .	
Reconstructive Surgery	<p>Cosmetic procedures are excluded.</p> <p>Medically necessary reconstructive surgery to correct a functional disorder resulting from a disease state, congenital disease or accidental injury is covered.</p>	PA required.
Respite Care	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. Services are limited to no more than 24 hours per month and 250 hours per year.	PA required

Services	Benefit Coverage Information	Additional Information
Second Opinions	Covered through network providers.	Arrange through Member Services.
Skilled Nursing Facilities	<p>Covered for short-term rehabilitative stay as determined by ODM.</p> <p>Long-term care in a Skilled Nursing Facility is excluded. Refer members to the appropriate County Department of Job and Family Services (CDJFS).</p>	PA required.
Sleep Studies	Covered as a medical condition if medically necessary and meets review criteria.	PA required. (PA not required for home studies)
Smoking Cessation	<p>Nicotine Replacement Medications are covered by ODM.</p> <p>Members should also enroll in a smoking cessation program to increase the likelihood of success. Molina Healthcare's smoking cessation program is for members who are ready to quit, and it is available at no cost to them. To participate in the program, members can contact Member Services.</p>	
Speech Therapy  (See also <a href="#">Neuro-develop- mental Therapy</a> )	Covered for medically necessary therapy for restoration or maintenance of function affected by illness, disability, condition or injury.	PA required on all speech therapy services after 30 visits .
Spinal Manipulations	Covered with limitations. See <a href="#">Chiropractic Care</a> .	
Sterilization (Tubal Ligation or Vasectomy)	<p>Covered for patients 21 years of age or older. <a href="#">Consent to Sterilization Form</a> required except in unique circumstances of an unscheduled clinical event that requires sterilization because of a life-threatening emergency.</p> <p>Must be a voluntary request, and the individual must be mentally competent. Reversal is excluded.</p> <p>See <a href="#">OAC 5160-21-02.2 Medicaid Covered Reproductive Health Services: Permanent Contraception/Sterilization Services and Hysterectomy</a>.</p>	PA required. <a href="#">Consent to Sterilization Form</a> (HHS-687 or Spanish version HHS-687-1) required, available online at <a href="http://www.MolinaHealthcare.com">www.MolinaHealthcare.com</a> .
Surgery Office Based	Covered surgical procedures performed in the office.	PA not required, except for pain management

Services	Benefit Coverage Information	Additional Information
		and podiatry surgical services.
Supplies (Non-Durable)	Must have a written prescription. Some limitations apply.	See Molina Healthcare's <a href="#">codified PA list</a> available at <a href="http://www.MolinaHealthcare.com">www.MolinaHealthcare.com</a> .
Temporomandibular Joint (TMJ) Syndrome	Covered if meets certain specifications.	PA required.
Transportation	<p>Up to 30 one-way/15 round-trips per calendar year for medically necessary appointments and WIC or ODM redetermination appointments.</p> <p>Transportation is also available if the member lives greater than 30 miles from the nearest network provider.</p>	Arranged through Transportation Services. Call at least 2 business days before the appointment.
Transsexual Surgery (Sexual Reassignment)	Not covered.	
Travel Immunizations	Not covered.	
Urgent Care	Covered.	
Vaccinations (Immunizations)	Covered.  (See also <a href="#">Travel Immunizations</a> )	
Vasectomy	See <a href="#">Sterilization</a> .	
Vision	<p><b>Eye Exams</b></p> <p><u>Medicaid</u>: One eye examination is covered every 12 months</p> <p><u>MyCare Ohio</u>: One eye examination is covered every 12 months for members 20 and younger, and members 60 and older. One eye examination covered every 24 months for members ages 21 to 59.</p> <p>Eye Glasses – One complete frame and pair of lenses, just lenses or just frames, or contact lenses with prior approval</p> <ul style="list-style-type: none"> <li>• One every 12 months for members 20 and younger, and members 60 and older.</li> <li>• One every 24 months for members ages 21 to 59</li> </ul>	Must be obtained through a network provider. Please contact March Vision.

Services	Benefit Coverage Information	Additional Information
	Vision correction surgery (radial keratotomy, Lasik) is excluded.	
Weight Loss	<p>Medically necessary weight loss is covered at a participating network inpatient Molina Healthcare facility when certain medical complications/conditions are present.</p> <p>Subject to medical review.</p> <p>Counseling by dietitians is covered for children with the following: growth disorders, metabolic diseases and inadequate dietary intake per Healthchek EPSDT guidelines.</p> <p>See <a href="#">Obesity Treatments</a>.</p>	<p>Some treatments require PA.</p> <p>Commercial weight loss programs (such as Weight Watchers, Jenny Craig) are not covered.</p> <p>Gym memberships are not covered.</p>
Well Adult Exams	<p>Yearly well adult examinations are covered.</p> <p>Not covered when required for employment or for other insurance coverage.</p>	
Well Child Exams	Covered.	

## March Vision Covered Services

March Vision will process and pay benefit eligible service codes regardless of diagnosis code when the member is benefit eligible for the service code billed.

If March Vision receives a subsequent claim for a benefit eligible service code where the member's benefit has been exhausted, any claims billed with a diagnosis code not found in the Refractive Diagnosis Code listing above will be processed with an indication to submit the claim to the health plan.

March Vision will process claim payment to optometrists, opticians and ophthalmologists.

Service Code	Service Code	Refractive Diagnosis Code
92002	V2212	36021
92004	V2213	3670
92012	V2214	3671
92014	V2215	36720
92015	V2218	36721
92070	V2219	36722
92071	V2220	36731
92072	V2221	36732

92310	V2299	3674
92311	V2300	36781
92312	V2301	36789
92340	V2302	3679
92341	V2303	V720
92342	V2304	
92352	V2305	
92353	V2306	
92370	V2307	
92371	V2308	
G0117	V2309	
G0118	V2310	
S0580	V2311	
S0620	V2312	
S0621	V2313	
V2020	V2314	
V2025	V2315	
V2100	V2320	
V2101	V2321	
V2102	V2500	
V2103	V2501	
V2104	V2502	
V2105	V2503	
V2106	V2510	
V2107	V2511	
V2108	V2512	
V2109	V2513	
V2110	V2520	
V2111	V2521	
V2112	V2522	
V2113	V2523	
V2114	V2530	
V2115	V2599	
V2118	V2700	
V2121	V2715	
V2199	V2744	
V2200	V2784	
V2201		
V2202		
V2203		
V2204		
V2205		
V2206		

V2207		
V2208		
V2209		
V2210		
V2211		

## Modifiers: HIPAA Compliant Modifiers That Impact Claims Payment

For a complete list of modifiers, please refer to the HCPCS/CPT books, or EncoderPro online.

<p><b>Ambulance Modifiers signifying to or from a Nursing Facility (NF)</b> will no longer be directly reimbursed for consumers residing in an NF. Claims should be directed to the Nursing Facility for reimbursement.</p> <ul style="list-style-type: none"> <li><a href="#">Ohio Administrative Code (OAC) 5160-15-02.8 Medical Transportation Services: Eligible Providers</a></li> </ul>	
<p><b>DN,ND,EN,NE,GN,NG,HN,NH,IN,NI,JN,NJ,NN,PN,PP,RN,RR,SN,SS,NX,XX</b></p>	
<p><b>Anesthesia Service Modifiers</b></p> <ul style="list-style-type: none"> <li><a href="#">Ohio Administrative Code (OAC) 5160-4-21 Physician Services: Anesthesia Services</a></li> </ul>	
<b>AA</b>	Anesthesia services personally furnished by anesthesiologist
<b>AD</b>	Medical supervision by a physician; more than four concurrent anesthesia procedures
<b>QK</b>	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
<b>QX</b>	Certified Registered Nurse Anesthetist (CRNA) with medical direction by a physician or anesthesia assistant with medical direction by an anesthesiologist
<b>QY</b>	Medical direction of one CRNA by an anesthesiologist
<b>QZ</b>	CRNA without medical direction by a physician

<p><b>Behavioral Health Service Modifiers</b></p> <ul style="list-style-type: none"> <li><a href="#">OAC 5160-4-29 Services Provided for the Diagnosis and Treatment of Mental and Emotional Disorders</a></li> </ul>	
<b>AH</b>	A clinical psychologist
<b>AJ</b>	A clinical social worker
<b>HN</b>	A bachelor's level clinical staff person
<b>HO</b>	A master's degree level trained professional
<b>HP</b>	A doctoral level trained professional
<p><b>Durable Medical Equipment (DME) Modifiers</b></p>	
<b>BO</b>	Enteral nutrition that is given orally
<b>NU</b>	New equipment is purchased
<b>QE</b>	Prescribed amount of oxygen is one liter per minute or less



<b>QF</b>	Prescribed amount of oxygen is greater than four liters per minute continuous and portable oxygen is also prescribed
<b>QG</b>	Prescribed amount of oxygen is greater than four liters per minute continuous and portable oxygen is not prescribed
<b>RP</b>	Repair/Replaced
<b>RR</b>	Short term rental
<b>U1</b>	Shall be used when oxygen services are provided via the use of a stationary oxygen concentrator to a consumer in a private residence <ul style="list-style-type: none"> <li>• <a href="#">OAC 5160-10-13 Oxygen: Covered Services and Limitations in a Private Residence</a></li> </ul>
<b>UE</b>	Used equipment

<b>Home Health Modifiers</b>		
		<ul style="list-style-type: none"> <li>• <a href="#">OAC 5160-1-39 Verification of Home Care Service Provision to Home Care Dependent Adults</a></li> <li>• <a href="#">OAC 5160-12-04 Home Health and Private Duty Nursing: Visit Policy</a></li> <li>• <a href="#">OAC 5160-12-05 Reimbursement: Home Health Services</a></li> <li>• <a href="#">OAC 5160-12-06 Reimbursement: Private Duty Nursing Services</a></li> </ul>
<b>U1</b>	Infusion therapy	Must be used when code T1000 is used for the purpose of home infusion therapy
<b>U2</b>	Second visit	Must be used to identify the second visit for the same type of service made by a provider on a date of service per consumer
<b>U3</b>	Third visit or more	Must be used to identify the third or more visit for the same type of service made by a provider on a date of service per consumer
<b>U4</b>	12 hours to 16 hours per visit	Must be used when a visit is more than 12 hours but not does not exceed 16 hours
<b>U5</b>	Healthcek	Must be used to identify the consumer receiving services due to Healthcek
<b>U6</b>	Private duty nursing (PDN) authorization	Must be used to identify consumer receiving increased services
<b>HQ</b>	Group visit	Indicates that a group visit was done

<b>Additional Modifiers</b>	
<b>22</b>	Increased procedural service requiring work substantially greater than typically required
<b>24</b>	Unrelated evaluation and management service by the same physician during the postoperative period <ul style="list-style-type: none"> <li>• <a href="#">OAC 5160-4-06 Physician Visits</a></li> </ul>
<b>26</b>	Professional component of a procedure that has both a technical and professional component <ul style="list-style-type: none"> <li>• <a href="#">OAC 5160-4-11 Diagnostic and Therapeutic Procedures</a></li> <li>• <a href="#">OAC 5160-4-17 Gastroenterology, Otorhinolaryngology, Endocrinology, Neurology,</a></li> </ul>

	<p><a href="#">Photodynamic Therapy and Special Dermatology Services</a></p> <ul style="list-style-type: none"> <li>• <a href="#">OAC 5160-1-60 Medicaid Payment</a></li> <li>• <a href="#">OAC 5160-4-25 Laboratory and Radiology Services</a></li> </ul>
<b>50</b>	<p>Bilateral procedures performed; reference <a href="#">OAC 5160-4-22 Surgical Services</a> for physician claims and <a href="#">Appendix A - Outpatient Hospital Modifiers</a>, to <a href="#">OAC 5160-2-21 Policies for Outpatient Hospital Services</a> for institutional claims.</p> <p>Modifier 50 should not be used to report:</p> <ul style="list-style-type: none"> <li>• Procedures that are bilateral by definition or their descriptions include the terminology as “bilateral” or “unilateral”.</li> <li>• Diagnostic and radiology facility services. Institutional claims received for an outpatient radiology service appended with modifier 50 will be denied.</li> </ul>
<b>51</b>	Multiple procedures performed; <a href="#">OAC 5160-4-22 Surgical Services</a>
<b>73</b>	<p>Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia</p> <ul style="list-style-type: none"> <li>• <a href="#">OAC 5160-2-21 Policies for Outpatient Hospital Services</a> (F)(3)</li> </ul>
<b>74</b>	<p>Discontinued outpatient hospital/ASC procedure after administration of anesthesia; hospital billing only</p> <ul style="list-style-type: none"> <li>• <a href="#">OAC 5160-2-21 Policies for Outpatient Hospital Services</a> (F)(3)</li> </ul>
<b>80,81</b>	<p>Assistant-at-surgery services; valid only for physicians</p> <ul style="list-style-type: none"> <li>• <a href="#">OAC 5160-4-22 Surgical Services</a></li> </ul>
<b>EP</b>	<p>Services provided as part of Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Healthchek program</p> <ul style="list-style-type: none"> <li>• <a href="#">OAC 5160-14-04 Reimbursement of EPSDT Services</a></li> </ul>
<b>GC</b>	<p>GC services performed in part by a resident under the direction of a teaching physician</p> <p><a href="#">OAC 5160-4-05 Teaching Practitioner Services</a></p>
<b>QW</b>	Waived laboratory procedure performed in accordance with CLIA guidelines
<b>GE</b>	<p>Services performed by a resident without the presence of a teaching physician under the primary care exception rule</p> <ul style="list-style-type: none"> <li>• <a href="#">OAC 5160-4-05 Teaching Practitioner Services</a></li> </ul>
<b>SA</b>	<p>Nurse practitioner rendering service in collaboration with physician</p> <ul style="list-style-type: none"> <li>• <a href="#">OAC 5160-8-27 Advanced Practice Nurses: Modifiers</a></li> </ul>
<b>SB</b>	Nurse mid-wife; <a href="#">OAC 5160-8-27 Advanced Practice Nurses: Modifiers</a>
<b>SG</b>	Facility charge for free-standing ASC
<b>TC</b>	<p>Technical component of procedure performed in a non-hospital setting</p> <ul style="list-style-type: none"> <li>• <a href="#">OAC 5160-4-11 Diagnostic and Therapeutic Procedures</a></li> <li>• <a href="#">OAC 5160-4-17 Gastroenterology, Otorhinolaryngology, Neurology and Special Dermatology Services</a></li> <li>• <a href="#">OAC 5160-1-60 Medicaid Payment</a></li> <li>• <a href="#">OAC 5160-4-25 Laboratory and Radiology Services</a></li> </ul>
<b>TH</b>	<p>Obstetrical treatment/services, prenatal or post-partum</p> <ul style="list-style-type: none"> <li>• <a href="#">OAC 5160-21-04 Pregnancy Related Services</a></li> </ul>
<b>UB</b>	<p>Transport of critically ill or injured patient more than 24 months of age</p> <ul style="list-style-type: none"> <li>• <a href="#">OAC 5160-4-06.1 Physician Attendance During Patient Transport</a></li> </ul>
<b>UC</b>	Clinical nurse specialist; <a href="#">OAC 5160-8-27 Advanced Practice Nurses: Modifiers</a>

<b>UD</b>	Physician assistant <ul style="list-style-type: none"> <li>• <a href="#">OAC 5160-4-03 Physician Assistants</a></li> </ul>
<b>GQ</b>	Telemedicine originating service was also present during the visit
<b>GT</b>	Telemedicine service rendered as a distant site

<b>Modifiers that will deny per medical policy as these services are not Ohio Medicaid covered benefits</b>	
<b>AS, 60, 61, 62, 66</b> (Co-surgeon, Minor Assistant at Surgery, and Physician Assistant) <ul style="list-style-type: none"> <li>• <a href="#">OAC 5160-4-03 Physician Assistants</a></li> </ul>	

<b>TYPE OF BILL CODES</b>	
This is a three-digit code; each digit is defined below.	
<b>First Digit</b> – Type of Facility	Code
Hospital	1
Skilled Nursing Facility	2
Home Health	3
Christian Science (Hospital)	4
Christian Science (Extended Care)	5
Intermediate Care	6
Clinic	7
Special Facility or Hospice	8

<b>Second Digit</b> – Bill Classifications (Excluding Clinics & Special Facilities)	Code
Inpatient	1
Outpatient	3
Other (for Hospital Referenced Diagnostic Services, or Home Health Not Under a Plan of Treatment)	4
Intermediate Care, Level I	5
Intermediate Care, Level II	6
Intermediate Care, Level III	7
Swing Beds	8

<b>Second Digit</b> – Bill Classifications (Clinics Only)	Code
Rural Health	1
Hospital Based or Independent Renal Dialysis Center	2
Free Standing	3
Other Rehabilitation Facility (ORF)	4
Other	9

<b>Second Digit</b> – Bill Classifications	Code
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<b>(Special Facility Only)</b>	
Hospice (Non-Hospital Based)	1
Hospice (Hospital Based)	2
Ambulatory Surgery Center (ASC)	3
Free-standing Birthing Center	4

<b>Third Digit – Frequency</b>	<b>Code</b>
Admit through Discharge Claim	1
Interim – First Claim	2
Interim – Continuing Claims	3
Interim – Last Claim	4
Late Charge Only	5
Adjustment of Prior Claim	6
Replacement of Prior Claim	7
Void/Cancel of Prior Claim	8

### CLAIM FORM REQUIREMENTS GUIDE

- **MANDATORY:** Item is required for all claims. If the item is left blank, the claim cannot be processed.
- **CONDITIONAL:** Item is required if applicable. Your claim may not be processed if blank.

#### CMS HCFA 1500 Claim Form Requirements

<b>FIELD</b>	<b>STATUS</b>	<b>INFORMATION</b>
1	CONDITIONAL	Insurance
1a	MANDATORY	Medicaid ID number
2	MANDATORY	Patient's name
3	MANDATORY	Patient's birth date and sex
4	CONDITIONAL	Insured's name
5	CONDITIONAL	Patient's address
6	CONDITIONAL	Patient relationship to insured
7	CONDITIONAL	Insured's address
8	CONDITIONAL	Patient status
9	CONDITIONAL	Other insured's name
9a	CONDITIONAL	Other insured's policy or group number
9b	CONDITIONAL	Other insured's date of birth and sex
9c	CONDITIONAL	Employer's name or school name
9d	CONDITIONAL	Insurance plan name or program name
10a	MANDATORY	Is patient's condition related to employment?
10b	MANDATORY	Is patient's condition related to auto accident?
10c	MANDATORY	Is patient's condition related to other accident?
10d	CONDITIONAL	Reserved for location use
11	CONDITIONAL	Insured's policy group or Federal Employee Compensation Act (FECA) number

11a	CONDITIONAL	Insured's date of birth
11b	CONDITIONAL	Employer's name or school name
11c	CONDITIONAL	Insurance plan name or program name
11d	CONDITIONAL	Is there another health benefit plan?
12	CONDITIONAL	Patient's or authorized person's signature
13	CONDITIONAL	Insured's or authorized person's signature
14	CONDITIONAL	Date of current illness, injury or last menstrual period (LMP) for pregnancy related
15	CONDITIONAL	If patient has had a same or similar illness, give first date
16	CONDITIONAL	Dates patient unable to work in current occupation
17	CONDITIONAL	Name of referring physician or other source
17a	CONDITIONAL	ID number of referring physician
17b	CONDITIONAL	10-digit National Provider Identifier (NPI) of referring physician or other source
18	CONDITIONAL	Hospitalization dates related to current services
19	CONDITIONAL	Reserved for local use
20	CONDITIONAL	Outside lab/charges
21	MANDATORY	Diagnosis or nature of illness or injury
22	CONDITIONAL	Medicaid resubmission code and original reference number
23	CONDITIONAL	Prior authorization number
Shaded area of 24a	CONDITIONAL	11-digit National Drug Code (NDC) number and its supplemental information
24a	MANDATORY	Date(s) of service
24b	MANDATORY	Place of service
24c	CONDITIONAL	Type of service
24d	MANDATORY	Procedures, services or supplies CPT/HCPCS code(s)
<b>CMS HCFA 1500 Claim Form Requirements continued...</b>		
<b>FIELD</b>	<b>STATUS</b>	<b>INFORMATION</b>
24e	MANDATORY	Diagnosis code (pointer)
24f	MANDATORY	Charges
24g	MANDATORY	Days or units
24h	CONDITIONAL	EPSDT/family plan
24i	MANDATORY	Electromyography (EMG)-emergency - Y or N
24j	MANDATORY	Rendering provider ID number, Medicaid ID number and NPI number
24k	CONDITIONAL	Reserved for local use
25	MANDATORY	Federal tax ID number (check box/SSN or EIN)
26	CONDITIONAL	Patient's account number
27	CONDITIONAL	Accept assignment
28	MANDATORY	Total charge
29	CONDITIONAL	Amount paid
30	MANDATORY	Balance due
31	MANDATORY	Signature of physician or supplier including degrees or credentials

32	CONDITIONAL	Name and address of facility where services were rendered
32a	CONDITIONAL	10-digit NPI number of service facility location
33	MANDATORY	Company name (as listed on W-9), address, zip code, phone number
33a	MANDATORY	10-digit NPI number of billing provider
33b	MANDATORY	Billing provider Medicaid ID number

**CLAIM FORM REQUIREMENTS GUIDE**

- **MANDATORY:** Item is required for all claims. If the item is left blank, the claim cannot be processed.
- **CONDITIONAL:** Item is required if applicable. Your claim may not be processed if blank.

**UB-04 Claim Form Requirements**

FIELD	STATUS	INFORMATION
1	MANDATORY	Company name as listed on W-9, address and phone number
2	CONDITIONAL	Pay-to name and address
3a	CONDITIONAL	Patient control number
3b	CONDITIONAL	Medical record number
4	MANDATORY	Type of bill
5	MANDATORY	Federal tax ID number
6	MANDATORY	Statement covers period
7	Not Used	Reserved for assignment by National Uniform Billing Committee (NUBC)
8a-b	MANDATORY	Patient identifier and name
9a-d	MANDATORY	Patient address
10	MANDATORY	Patient date of birth
11	MANDATORY	Patient sex
12	MANDATORY	Admission/start of care date
13	MANDATORY	Admission hour (for inpatient only)
14	MANDATORY	Type of admission
15	MANDATORY	Source of admission
16	CONDITIONAL	Discharge hour
17	MANDATORY	Patient discharge status*
18-28	CONDITIONAL	Condition codes (if applicable)
29	CONDITIONAL	Accident state
30	Not Used	Reserved for assignment by NUBC
31-34	CONDITIONAL	Occurrence codes and dates (if applicable)*
35-36	CONDITIONAL	Occurrence span codes and dates
37	Not Used	Reserved for assignment by NUBC
38a-d	CONDITIONAL	Name and address of the party responsible for the bill
39-41 a-d	CONDITIONAL	Value codes and amounts (if applicable)*
42	MANDATORY	Revenue codes*
43	MANDATORY	Revenue description

43	CONDITIONAL	11-digit NDC number and its supplemental information
44	MANDATORY	HCPCS code/rates (if applicable)
45	MANDATORY	Service date
46	CONDITIONAL	Service units
47	MANDATORY	Total charges (by revenue code/HCPCS)
48	CONDITIONAL	Non-covered charges
49	Blank	Reserved for assignment by the NUBC
50	MANDATORY	Payer name
51	MANDATORY	Health plan identification number
52	CONDITIONAL	Release of information certification indicator
53	CONDITIONAL	Assignment of benefits certification indicator
54	CONDITIONAL	Prior payments (if applicable)
55	MANDATORY	Estimated amount due from payer
56	MANDATORY	Billing provider NPI number
57	MANDATORY	Billing provider Medicaid number
58	CONDITIONAL	Name of insured
59	CONDITIONAL	Patient's relationship to insured
60	MANDATORY	Member Medicaid recipient ID number
61	CONDITIONAL	Insured's group name
62	CONDITIONAL	Insured's group number
63	CONDITIONAL	Treatment authorization code
64	CONDITIONAL	Document control number
65	CONDITIONAL	Employer name (of the insured)
66	MANDATORY	Diagnosis and procedure code qualifier
67	MANDATORY	Principal diagnosis code and present on admission indicator
67a-q	MANDATORY	Other diagnosis codes
68	Not Used	Reserved for assignment for the NUBC
69	MANDATORY	Admitting diagnosis code
70a-c	CONDITIONAL	Patient's reason for visit
71	CONDITIONAL	Prospective payment system (PPS) code
72a-c	CONDITIONAL	External cause of injury code
73	Not Used	Reserved for assignment of the NUBC
74	CONDITIONAL	Principle procedure code and date
74a-e	CONDITIONAL	Other procedure codes and dates
75	Not Used	Reserved for assignment of the NUBC
76	CONDITIONAL	Attending provider name and identifiers
77	CONDITIONAL	Operating physician name and identifiers
78-79	CONDITIONAL	Other provider name and identifiers
80	CONDITIONAL	Remarks field
81	Not Used	Code – code field

\*Refer to Uniform Billing Manual for List of Codes

## Medicaid Billing Guidelines

### *Advanced Practice Nurses (APN)*

When billing for any service provided by an APN, in accordance with Ohio [OAC 5160-8-27 Advanced Practice Nurses: Modifiers](#), all services must be billed with the appropriate modifier to denote the type of APN that provided the service:

- Bill the modifier "SA" e.g. 99201SA, if the APN is a nurse practitioner
- Bill the modifier "SB" e.g. 99201SB, if the APN is a nurse mid-wife
- Bill the modifier "UC" e.g. 99201UC if the APN is a clinical nurse specialist

In accordance with [OAC 5160-8-23 Advanced Practice Nurses: Coverage and Limitations](#), APNs are subject to the following coverage and limitations:

- APNs are not eligible to bill or be reimbursed for CPT code 99223.
- Emergency room visit codes 99284 and 99285 are not covered if billed by an APN who is in an independent practice as defined in rule [OAC 5160-8-22 Advanced Practice Nurses Practice Arrangements and Reimbursement](#).

APN services will be reimbursed, in accordance with [OAC 5160-8-22 Advanced Practice Nurses Practice Arrangements and Reimbursement](#), the lesser of the provider's billed charge or one of the following:

- 85 percent of the provider contracted rate when services are provided by an APN in the following places of service: inpatient hospital, outpatient hospital, or hospital emergency department
- 100 percent of the provider contracted rate when services are provided by an APN in any non-hospital setting

### *Anesthesia Services*

Molina Healthcare requires all anesthesia services be billed with the number of actual minutes in the unit's field (item 24G) of the CMS-1500 form. The minutes will be calculated by 15-minute increments and rounded to the nearest tenth to determine the appropriate units to be paid. If the claim is submitted without the minutes in field 24G, the claim will be denied.

Anesthesia services will not be paid for surgeries that are non-covered.

### *Bilateral Surgery*

Bilateral procedures performed – reference [OAC 5160-4-22 Surgical Services](#) for physician claims and [OAC Appendix A – Outpatient Hospital Modifiers](#) for institutional claims.

Bilateral surgeries are procedures performed on both sides of the body at the same operative session or on the same day (two ears, two feet, two eyes, etc.).

Guidelines for bilateral procedures are as follows:



- The surgical procedure should be billed on a single line with modifier 50 and one unit.
- Modifier 50 should not be used to report:
  - Procedures that are bilateral by definition or their descriptions include the terminology such as “bilateral” or “unilateral”.
  - Diagnostic and radiology facility services. Institutional claims received for an outpatient radiology service appended with modifier 50 will be denied.

### ***Chronic Conditions***

In order for Molina Healthcare to accurately identify members with chronic conditions that may be eligible for one of the Disease Management or Care Management programs, please see the suggested billing tips listed below:

- For members with chronic illness, always include appropriate chronic and disability diagnoses on all claims.
- Document chronic disease (please note, Molina Healthcare has identified asthma as the most common diagnosis code not reported) whenever it is appropriate to do so. This includes appointments when prescription refills are written for chronic conditions.
- Be specific on diagnosis coding; always use the most specific appropriate diagnosis code available.

### ***Diagnosis Pointers***

A single encounter may frequently correlate with multiple procedures and/or diagnosis codes. Diagnosis pointers are required if at least one diagnosis code appears on the claim and must be present with the line item with which it is associated. This is a single digit field used to “point” to the most appropriate ICD-9 codes by linking the corresponding diagnosis reference number (1, 2, 3, and/or 4) from the diagnosis indicated in item number 21. Do not enter the actual ICD-9 codes or narratives in item number 21.

A pointer should be submitted to the claim diagnosis code in the order of importance. The remaining diagnosis pointers are used in declining level of importance to the service line. The diagnosis pointer should be reported in the following fields:

### **Paper Claims**

Item Number 24E

### **Electronic Claims**

For EDI claims, please reference the appropriate ODM Companion Guide (837P), found on the [ODM Trading Partner website](http://www.jfs.ohio.gov) at [www.jfs.ohio.gov](http://www.jfs.ohio.gov), for the appropriate loop and segments.

### ***Dialysis Services***

Molina Healthcare requires one service line per date of service with a maximum unit of one for dialysis services. If a claim is received with a date span billing multiple units on a single charge line, the charge line will be denied.

### ***Durable Medical Equipment***

Molina Healthcare follows the DME guidelines as referenced in the **ODM Supply List and the Orthotic and Prosthetic List**. It is imperative that appropriate billing be used to identify the services provided and process claims accurately.

- [5160-10-03 Appendix A – Medicaid Supply List](#)
- [5160-10-20 Appendix A – List of Orthotic and Prosthetic Procedures](#)

Molina Healthcare follows the indicators published on the ODM Medicaid Supply List listed below:

- "Max Units" indicator – A maximum allowable (MAX) indicator means the maximum quantity of the item that may be reimbursed during the time period specified, unless an additional quantity has been prior authorized. If there is no maximum quantity indicated, the quantity authorized will be based on medical necessity as determined by Molina Healthcare.
- "RNT/P" indicator
  - "RO" means item is always rented – A DME code with this indicator should be billed with the RR modifier for the applicable rental period.
  - "PP" means item is always purchased – A DME code with this indicator should NOT be billed with a modifier.
  - "R/P" means item is designated as rent to purchase as described in [OAC 5160-10-05 Reimbursement for Covered Services](#) – A DME code with this indicator MUST be billed with a modifier.

Claims payment on rent to purchase DME codes billed without the NU modifier will be paid as a monthly rental. This change will ensure monthly rental DME items are reimbursed as such and reduce your administrative work to post recoveries.

### ***Durable Medical Equipment (DME), Medical Supplies and Parenteral Nutrition***

Molina Healthcare billing requirements are:

- Submit one service line per each date of service.
- Use the shipping date as the date of service on the claim if a shipping service or mail order is utilized.
- Always include the appropriate modifier on all DME claims for rent to purchase items listed in the Ohio Medicaid Supply List.
  - RR modifier is required when item is rented.
  - NU modifier is required when item is purchased.

### ***Emergency Room Evaluation and Management with Modifier 25***

When circumstances warrant the billing of a modifier 25 for physician claims that include an Emergency Room Evaluation and Management code (ER E/M) when billed with a surgical procedure code, Molina Healthcare requires medical records with the initial claim submission.

### ***Enteral Nutrition Formula – B Code Products***

Molina Healthcare billing requirements are:

- 1 unit = 100 calories (calories/100)
- 11-digit NDC number must be present on claim
- Submit one service line per each date of service.
- Use the shipping date as the date of service on the claim if a shipping service or mail order is utilized.

Please see the below examples and refer to the ODM supply list and OAC [5160-10-05 Reimbursement for Covered Services for](#) further details.

<b>Example:</b> B4220 PARENTERAL NUTRITION SUPPLY KIT; PREMIX, COMPLETE- PER DAY 1/DAY PP			
<b>Incorrect billing with a date span</b>			
DOS	Service Code	Billed Charges	Units
11/28/10-11/30/10	B4220	\$60.00	3
<b>Appropriate billing is equal to the shipping date</b>			
DOS	Service Code	Billed Charges	Units
11/28/10-11/28/10	B4220	\$60.00	3

<b>Example:</b> E0565 - COMPRESSOR, AIR POWER SOURCE FOR EQUIPMENT NOT SELF-CONTAINED OR CYLINDER - EACH 1/4 YRS R/P			
DOS	Service Code/Modifier	Billed Charges	Units
11/28/10-11/28/10	E0565 RR	\$100.00	1 (1st month rental)
12/28/10-12/28/10	E0565 RR	\$100.00	1 (2nd month rental)
01/28/11-01/28/11	E0565 RR	\$100.00	1 (3rd month rental)
02/28/11-02/28/11	E0565 NU	\$600.00	1 (purchased)

<b>Example:</b> B4160 - PEDIASURE LIQUID VANILLA (NDC # 70074-0558-98) for 29,900 calories			
DOS	Service Code	Billed Charges	Units (Calorie units)
11/28/10-11/28/10	B4160	\$450.00	299

### ***Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) Healthchek Services/Family Planning***

Molina Healthcare requires the EPSDT data reported in block 24H be submitted on all EPSDT claims. If this field is left blank, the claim will be denied. ODM is federally required to annually report the number of EPSDT visits and referrals for follow-up or corrective treatment for Medicaid-eligible recipients 0 to 20 years of age. The EPSDT services should be reported as follows:

#### Paper Claims

Per [ODM Instructions for Completing the CMS-1500 Claim Form](#), the referral field indicator should be reported in field 24H for Healthchek/EPSTD services as follows:

*Lower, Unshaded Area*

- Enter ‘E’ in the lower, unshaded area in field 24H if the service was related to Healthchek (EPSTD).
- Enter ‘F’ in the lower, unshaded area in field 24H if the service was related to family planning.
- Enter ‘B’ in the lower, unshaded area in field 24H if the service was related to both Healthchek (EPSTD) and family planning.

*Upper, Shaded Area*

- If either E or B is entered in the lower, unshaded area, then add the appropriate condition indicator in the upper, shaded area in field 24H using one of the following:
  - NU (No Healthchek (EPSTD) referral was given)
  - AV (Referral was offered, but the individual refused it)
  - ST (New services requested)
  - S2 (Under treatment)

Electronic Claims

Per ODM [837 Health Care Claim Professional](#) Companion Guide, completion of CRC02 and CRC03 are required for electronic claims.

Select the appropriate response in Loop 2300 Segment CRC02, “Was an EPSTD referral given to the patient?” as follows:

- Enter ‘Y’ in Loop 2300, Segment CRC02 if the service was Healthchek and follow-up is required and a referral is made.
- Enter ‘N’ in Loop 2300, Segment CRC02 if the service is a Healthchek and no follow-up services were required.

Select the appropriate condition indicators in Loop 2300, Segment CRC03.

- If response to CRC02 is Yes, use one of the following in Loop 2400, Segment SV111:
  - AV (Referral was offered, but the individual refused it)
  - ST (New services requested)
  - S2 (Under treatment)
- If response to CRC02 is No, use the following:
  - NU (No Healthchek (EPSTD) referral was given)

Enter ‘Y’ in Loop 2400, Segment SV112 if the service involved family planning.

For additional information, please reference the appropriate [ODM Companion Guide \(837P\)](#) found on the [ODM Trading Partner website](#) at <http://jfs.ohio.gov>.

EPSTD Services:

- Preventive Medicine Services
  - New Patient under 1 year 99381
  - New Patient (ages 1 to 4 years) 99382
  - New Patient (ages 5 to 11 years) 99383
  - New Patient (ages 12 to 17 years) 99384
  - New Patient (ages 18 to 39 years) 99385
  - Established patient under 1 year 99391
  - Established patient (ages 1 to 4 years) 99392
  - Established patient (ages 5 to 11 years) 99393
  - Established patient (ages 12 to 17 years) 99394
  - Established patient (ages 18 to 39 years) 99395
- Evaluation and Management Codes
  - New Patient 99201-99205
  - Established Patient 99211-99215

**NOTE:** These CPT codes must be used in conjunction with diagnosis:

- Encounter for health supervision and care of infant, child or foundling
- Encounter for health supervision and care of other healthy infant and child
- Encounter for routine child health examination with normal or abnormal findings
- Encounter for general adult medical examination with normal or abnormal findings
- Encounter for examination for admission to educational institution or residential institution, for sports, driver's license, insurance, adoption, or other administrative purposes
- Encounter for paternity testing, blood alcohol or blood drug tests, or other exam and observation for medico-legal reasons
- Encounter for other general examination
- Encounter for examination for normal comparison and control in clinical research program
- Encounter for examination of potential donor of organ and tissue
- Encounter for examination for period of delayed growth in childhood with or without abnormal findings

**Billing for Preventive and Sick Visits on the Same Date of Service**

Did you know that Molina Healthcare will pay for both a new/established patient preventative/well visit with a new/established patient sick visit for the same member on the same date of service if the diagnosis codes billed support payment of both codes? Be sure to bill the correct diagnosis codes and bill the new/established patient E&M with modifier 25 to ensure accurate payment. Please note that medical documentation is not needed with modifier 25.

***Home Health Services***

- Per [OAC 5160-12-01 Home Health Services: Provision Requirements, Coverage and Service Specification](#), a face-to-face encounter with the qualifying treating physician must be done within 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, Form JFS 07137, documenting this visit and the reasons for requesting home care.

- The provider must have the certificate of medical necessity on the appropriate JFS 07137 form on file and available for review upon request.

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

HQ modifier must be appended to both mom and baby's claim, indicating a group visit.

Pursuant to [OAC 5160-12-05 Reimbursement: Home Health Services](#), the amount of reimbursement for each visit shall be the lesser of the provider's billed charge or 75 percent of the provider's contracted rate when billing with the modifier HQ "group setting" for group visits conducted in accordance with [OAC 5160-12-04 Home Health and Private Duty Nursing: Visit Policy](#).

### ***Respite Care Services***

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 Managed Health Care Programs: Covered Services](#))

All of the following criteria are 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 age 21 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 [5160-3-08 Criteria for Nursing Facility-Based Level of Care](#).
- The member must require skilled nursing or skilled rehabilitation services at least once per week.

- The member must have received at least 14 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.

HCPC G0156 will be the code used to bill for respite services and will require the GY modifier in addition.

**Other Modifiers that can be used in addition to GY for respite care services:**

- U2 – Second Visit – Must be used to identify the second visit for the same type of service made by the same provider on the same date of service per member.
- U3 – Third Visit or more – Must be used to identify the third or more visit for the same type of service made by the same provider on the same date of service per member
- HQ – Group Visit – Indicates that a group visit was done

***Inpatient Emergency Room (ER) Admissions***

Molina Healthcare requires medical records with the initial claim submission. This is required so the claim can be reviewed for an inpatient authorization if an authorization is not on file due to the emergency situation.

***Interim Claims – Type of Bill (TOB) 112, 113, and 114***

Upon discharge of a Molina Healthcare member, the inpatient hospital claim should be submitted with the complete confinement on a corrected claim with TOB 117 if interim claims were previously processed. Molina Healthcare requires a corrected claim with the complete confinement to ensure accurate claims payment.

***Locum Tenens Services Substituting for an Absent Provider***

A Molina Healthcare contracted provider may arrange for a temporary replacement to provide services to his/her patients as an independent contractor for a limited time due to an illness, a pregnancy, vacation, etc. This is known as a locum tenens arrangement.

- **Billing and Documentation Requirements**
  - Provider's office must keep a record of each service provided by the locum tenens provider.
  - Claims submitted for locum tenens services performed within the approved timeframe, not to exceed 120 days, should be billed with the locum tenens name in field 31 and NPI in field 24J of the CMS-1500 claim form.
  - Do not bill with the absent provider's information as the rendering provider.
  - The tax identification number in field 25 and the NPI in field 33A should be billed with the absent provider's office or group practice information. Modifier Q6 is not required.

- The payment will be made to the absent provider’s office or group practice at the contracted rate. It is assumed that the locum tenens physician will be compensated by the regular physician on a per diem or similar fee for time basis.

<b>Locum Tenens Provider</b>	<b>Requirement</b>
Claims are submitted by the absent provider’s office or group practice and that office receives payment.	Yes
Should modifier Q6 be billed to identify arrangement?	No
Must be a Medicaid participating provider.	Yes
May be employed by the same group as the regular/absent provider.	No
Must submit an attachment to Molina Healthcare with locum tenens provider information prior to seeing Molina Healthcare members each time the provider will be substituting for a Molina Healthcare participating provider.	Yes
Maximum timeframe allowed per provider, per leave of absence.	120 days

### **Maternity Care**

Last menstrual period (LMP) date requirement: In accordance with [OAC 5160-26-06 Managed Health Care Programs: Program Integrity – Fraud and Abuse, Audits, Reporting and Record Retention](#), Molina Healthcare requires the LMP date on pregnancy-related services billed on a CMS-1500. Claims received with the following perinatal and/or delivery CPT code(s) must include an LMP date and meet the required date range specified below. Facility claims billed on a UB-04 claim form are excluded from the LMP requirement.

<b>Delivery CPT Codes</b>
LMP date <b>must</b> meet the required date range of <b>119 to 315</b> days prior to the delivery DOS for the following codes:
59400, 59510, 59610, or 59618
<b>Note:</b> If the LMP date field is left blank or falls outside of the 119 and 315 days, the entire claim will be denied.

<b>Perinatal CPT Codes</b>
LMP date <b>must</b> meet the required date range of <b>1 to 315</b> days prior to the “to date” of the perinatal DOS for the following codes:
59425, 59426, 76801, 76802, 76805, 76810, 76811, 76812, 76815, 76816, 76818, and 80055
<b>Note:</b> If the LMP date field is left blank or falls outside of the 1 and 315 days, the entire claim will be denied.

Molina Healthcare realizes this information may not always be available to a radiologist or laboratory, particularly for services not performed face-to-face with the member or the provider who delivers the baby, especially if the member received prenatal care from another provider/facility. To avoid any unnecessary claim denials, radiologists and laboratories must



assure the written order or requisition from the treating practitioner includes an LMP date, when applicable. Please remember, participating providers may estimate the LMP date on delivery claims based on the gestational age of the child at birth.

#### CMS-1500

- The LMP should be reported as Item 10a-c – Patient’s Condition – Check "YES" or "NO" to indicate whether employment, auto, or other accident involvement applies to one or more of the services described in Item 24.
- Item 14 – Enter the six-digit (MMDDYY) or eight-digit (MMDDCCYY) date of the LMP.

For EDI claims, please reference the appropriate ODM Companion Guide (837P/837I), found on the [ODM Trading Partner website](http://www.jfs.ohio.gov) at [www.jfs.ohio.gov](http://www.jfs.ohio.gov), for the appropriate loop and segments.

Molina Healthcare will reimburse providers for a prenatal risk assessment (PRA) by billing HCPCS code H1000 and 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 [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.

[Forms](http://www.MolinaHealthcare.com) are available at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com).

#### Well Care through the Perinatal Period

Consider providing an annual well exam for your patients in addition to prenatal or postpartum care. The services required for a well exam (health and developmental history, both physical and mental, a physical exam, and health education/anticipatory guidance) are often provided as part of the prenatal or postpartum exam, but may not have been coded in the past.

- Preventive services may be rendered on visits other than specific well care visits, regardless of the primary intent of the visit.
- Well visit and postpartum visit can be paid for the same office visit, provided that the appropriate procedure and diagnosis codes are included for both services.

To ensure accurate encounter reporting for HEDIS<sup>®</sup> and ODM requirements, the following ICD-9 codes should not be billed for a *non-delivery* event.

<b>ICD-9 Diagnosis Codes</b>	
<b>V24.0</b>	Postpartum care and examination immediately after delivery
<b>V27.x</b>	Outcome of delivery (must be used in conjunction with one of the ICD-9 codes and/or CPT codes listed below)
<b>650</b>	Normal delivery
<b>OR</b>	
Any of the following codes that includes a fifth digit equal to 1 or 2:	
<b>640-649</b>	Complications mainly related to pregnancy

<b>651-659</b>	Normal delivery and other indications for care in pregnancy, labor and delivery
<b>660-669</b>	Complications occurring mainly during the course of labor and delivery
<b>670-676</b>	Complications of the puerperal
<b>CPT Codes</b>	
<b>59400-59410</b>	Vaginal delivery, antepartum and postpartum care
<b>59510-59515</b>	Cesarean delivery
<b>59610-59622</b>	Delivery after previous cesarean delivery

<b>ICD-9 Procedure Codes:</b>	
<b>72.x</b>	Forceps, vacuum and breech delivery
<b>73.09</b>	Other artificial rupture of membranes at the time of delivery
<b>73.22</b>	Internal and combined version with extraction
<b>73.51</b>	Manual assisted delivery – manual rotation of fetal head
<b>73.59</b>	Manually assisted delivery – other manually assisted delivery
<b>73.8</b>	Operations on fetus to facilitate delivery
<b>73.9x</b>	Other operations assisting delivery
<b>74.x</b>	Cesarean section and removal of fetus

### ***National Drug Codes (NDC)***

NDCs are codes assigned to each drug package. Each NDC is an 11-digit number, sometimes including dashes in the format (e.g. 55555-4444-22). They specifically identify the manufacturer, product and package size.

In accordance with ODM payment policy, a valid 11-digit NDC number is required to be billed at the detail level when a claim is submitted with a CPT/HCPCS code that represents a drug. Federal law requires that any code for a drug covered by Medicaid must be submitted with the NDC. The following codes require an NDC number:

- HCPCS J0120-J9999
- HCPCS Q0138-Q0139
- HCPCS Q0515
- HCPCS Q2009-Q2010
- HCPCS Q2017
- HCPCS Q2026-Q2027
- HCPCS Q2050
- HCPCS Q3025
- HCPCS Q4081
- HCPCS Q4096-Q4099
- HCPCS S0145
- HCPCS S0148

- HCPCS S0166
- HCPCS B4157-B4162
- CPT codes in the 90281-90399 series
- HCPCS B4164-B4216
- HCPCS B4220-B4224
- HCPCS B4240

NDC numbers must meet the following requirements:

- A valid/active 11-digit NDC number
- When the package of a drug only includes a 10-digit NDC number, the 10 digits must be converted to 11 digits by adding a leading zero to only one segment.
- Reported without dashes or spaces

If the NDC information is missing or invalid, the claim line(s) will be denied.

When the package of a drug only includes a 10-digit NDC number, the 10 digits must be converted to 11 digits by adding a leading zero to only one segment as indicated below.

- If the first segment contains only four digits, add a leading zero to the segment
- If the second segment contains only three digits, add a leading zero to the segment
- If the third segment contains only one digit, add a leading zero to the segment

This applies to the following claim types:

#### Paper Claims

- CMS 1500 – Professional Claims
  - Populate the 11-digit NDC number on the shaded area of field 24A.
- UB-04 – **All outpatient facility claims including** End-Stage Renal Disease Clinic Claims (bill type 13X and 72X)
  - Populate the 11-digit NDC number on shaded area of field 43.

#### Electronic Claims

For EDI claims, please reference the appropriate ODM Companion Guide (837I/837P), found on the [ODM Trading Partner website](http://jfs.ohio.gov) at <http://jfs.ohio.gov>, for the appropriate loop and segments to report the following:

- Qualifier of ‘N4’
- 11-digit NDC number (do not enter hyphens or spaces with the NDC)
- Unit quantity
- Unit of measurement qualifier
  - F2 (International Unit)
  - GR (Gram)
  - ML (Milliliter)
  - UN (Unit)

### ***Newborn Claims***

Molina Healthcare requires providers to report the birth weight on all newborn institutional claims. To report this data, the appropriate value code must be used:

- Paper UB-04: Report in block 39, 40 or 41 using value code “54” and the newborn’s birth weight, in grams. Please note: providers should include decimal points when reporting birth weight. For example, if the birth weight is 1,000 grams, then the provider should report 1000.00 along with value code 54.
- Electronic: Report birth weight as a monetary amount. Reference the appropriate ODM Companion Guide (837I), found on the [ODM Trading Partner website](http://jfs.ohio.gov) at <http://jfs.ohio.gov>, for the appropriate loop and segments.

### ***National Provider Identification Number (NPI)***

Molina Healthcare requires all claims and encounters, both electronic and paper formats, include an NPI in all claim fields that require provider identification, as provided below, to avoid any unnecessary claim rejections.

- In accordance with 5010 requirements, NPIs are mandated on all electronic transactions per HIPAA.
- The use of an NPI on paper claims is a Molina Healthcare requirement. Paper claims without an NPI ***will be denied, if received on or after Dec. 1, 2012.***

Based on this requirement, please be sure to include NPIs on all claim submissions to Molina Healthcare.

If you do not have an NPI, please visit [www.nppes.cms.hhs.gov](http://www.nppes.cms.hhs.gov) to obtain an NPI. Any changes to an NPI should also be reported to Molina Healthcare within 30 days of the change.

<b>NPI Required Fields: CMS 1500</b>	<b>Required?</b>	<b>Field Location</b>
Billing Provider NPI	Yes	Box 33a
Rendering Provider NPI	Yes	Box 24j
Referring Provider NPI	If Applicable	Box 17b
Facility Provider NPI	If Applicable	Box 32a
<b>NPI Required Fields: UB04</b>	<b>Required?</b>	<b>Field Location</b>
Billing Provider NPI	Yes	Box 56
Attending Provider NPI	If Applicable	Box 76
Operating Provider NPI	If Applicable	Box 77
Other Provider NPI	If Applicable	Box 78
Other Provider NPI	If Applicable	Box 79

Molina Healthcare recommends all providers reference the appropriate ODM Companion Guide (837I, 837P) found on the [ODM Trading Partner website](http://www.jfs.ohio.gov) at [www.jfs.ohio.gov](http://www.jfs.ohio.gov), for the appropriate loop and segments to ensure all 5010 requirements are being met.

For HIPAA transaction and code set (TCS) questions or concerns, please call our toll-free HIPAA Provider Hotline at **(866) MOLINA2 [(866) 665-4622]**.

### *Obstetrical Care*

Molina Healthcare is committed to promoting primary preventive care for members. In an effort to ensure that female members receive all needed preventive care, Molina Healthcare encourages OB/GYNs to provide preventive care services in conjunction with obstetrical/gynecological visits.

When providing care to Molina Healthcare members, consider performing an annual well exam in addition to obstetric/gynecological services.

Services required during a well exam that should be documented in the medical record are:

- A health and developmental history (physical and mental)
- A physical exam
- Health education/anticipatory guidance

Note that:

- Preventive services may be rendered on visits other than well care visits, *regardless of the primary intent of the visit.*
- The appropriate diagnosis and procedure codes must be billed to support each service.
- A well exam and an ill visit can be paid for the same office visit, provided that the appropriate procedure and diagnosis codes are included for both services.

### **Coding for Well Care Services with Obstetric/Gynecological Services**

<b>Well Care Visit</b>	<b>CPT</b>	<b>ICD 9</b>
Adolescent/adult preventative / well care visits (12 to 39 years)	99384-99385, 99394-99395	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9
Obstetric/gynecological well care visits	99201-99205, 99211-99215, 99241-99245	640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 649.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, 678.x3, 679.x3, V22.x-V23.xx, V28.x

### *Outpatient Hospital Services*

In accordance with [OAC 5160-2-21 Policies for Outpatient Hospital Services](#), additional payment will be made for dates of service on or after March 31, 2010 for the following:

- Stand alone revenue codes billed with IV therapy
  - Line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) when the claim carries IV therapy CPT code 96365, 96366, 96367, or 96368 that does not include dialysis, chemotherapy, or surgical services.

- Independently billed pharmacy or medical supplies
  - Line items that carry revenue center code 025X (with no CPT code present), 0636 (with a valid HCPCS J code) and/or revenue center code 027X (with no CPT code present) that does not include dialysis, chemotherapy, surgical, clinic, emergency room, radiology, ancillary, laboratory, or pregnancy related services.

### ***Payment Policy for Services without a Published Reimbursement Rate***

Reimbursement for services that are listed without a published rate in the Medicaid Fee Schedule appendices or specified as set forth in an OAC, and deemed medically necessary, is made in accordance with the provider contract. When the contract is silent, the payment amount is based on the default 30 percent of the billed charge. Providers must bill their usual and customary charge.

See [OAC 5160-2-21, Appendix A Outpatient Modifiers](#) for a list of procedure codes that were deemed inpatient only by the Centers for Medicare and Medicaid Services (CMS) and removed from Appendix C.

### ***Sterilization/Delivery Services***

Pursuant to [OAC 5160-21-02.2 Medicaid Covered Reproductive Health Services: Permanent Contraception/Sterilization Services and Hysterectomy](#), claims received for sterilization services are paid only if the required criteria are met and the appropriate Consent for Sterilization Form (, HHS-687 or HHS-687-1) has been received per the OAC. In addition, reimbursement will not be made for associated services such as anesthesia, laboratory tests, or hospital services if the sterilization service itself cannot be reimbursed. However, sterilization claims received without a valid consent form attached that includes services unrelated to the sterilization i.e., delivery services, will be processed as follows:

- Inpatient hospital claims on a UB-04 will be denied.
  - Reimbursement can be made for charges unrelated to the sterilization procedure when a corrected claim is received, removing all of the sterilization related charges and ICD-9 diagnosis/procedure codes.
- Outpatient hospital claims on a UB-04 will be denied.
- Physician services on the HCFA-1500 claim form will deny the line items for the sterilization services and process the line items unrelated to the sterilization services for payment.
  - No corrected claim form is required.

[Consent to Sterilization Form](#) is available at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com) or on the [ODM website](#).

### **Guidelines for Completing CONSENT TO STERILIZATION FORM HHS-687 (10/12)**

*Providers: Complete all fields unless optional is indicated.*

[Click here](#) to view the Consent to Sterilization Form provided at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com).

**Consent to Sterilization**

1. Doctor or Clinic – Name of physician or clinic providing the patient with the form.
2. Specify Type of Operation – List the name of the surgical procedure to be performed (e.g. tubal ligation, **Essure**®, bilateral partial salpingectomy (BPS), tubal occlusion, vasectomy, etc.). Must match the other “specify type of operation” field in the left column and the “specify type of operation” field under the Statement of Person Obtaining Consent.
3. Date – Patient’s date of birth.
4. Name of Individual – Patient’s first and last name.
5. Doctor or Clinic – Name of physician who will be performing the surgical procedure.
6. Specify Type of Operation – List the name of the surgical procedure to be performed (e.g. tubal ligation, **Essure**®, BPS, tubal occlusion, vasectomy, etc.). Must match the other “specify type of operation” field in the left column and the “specify type of operation” field under the Statement of Person Obtaining Consent.
7. Signature – Patient’s signature.
8. Date – Date patient signed consent form (must match the signature date of the Person Obtaining Consent). We do not and cannot accept date stamps.
  - a. Note: The procedure cannot be performed until a full 30 days after this date and must be performed within 180 days of this date.
9. Optional – Patient can check the box of giving his or her race and ethnicity.

**Interpreters Statement (Optional)**

10. Optional – The interpreter defines the language used in the interpretation.
11. Optional – The interpreter signs his or her name.
12. Optional – The interpreter enters the date he or she read the statement to the patient.

**Statement of Person Obtaining Consent**

13. Name of Individual – Patient’s first and last name.
14. Specify Type of Operation – List the name of the surgical procedure to be performed (e.g. tubal ligation, **Essure**®, BPS, tubal occlusion, vasectomy, etc.). Must match the other “specify type of operation” field in the left column and the “specify type of operation” field under the Statement of Person Obtaining Consent.
15. Signature of Person Obtaining Consent – Physician or physician representative must sign. We do not and cannot accept signature stamps.
16. Date – Date consent was obtained (must match the signature date of the patient). We do not and cannot accept date stamps.
17. Facility – List the name of the doctor or clinic where the Person Obtaining Consent is located.
18. Address – List the facility’s complete address (including city, state and zip code).

**Physician’s Statement**

19. Name of Individual – Patient’s first and last name.
20. Date of Sterilization – Date the surgical procedure was performed.

21. Specify Type of Operation – List the surgical procedure that was actually performed. It does not have to match the other three areas (e.g. tubal ligation, **Essure**®, BPS, tubal occlusion, vasectomy, etc.).
22. Paragraph 1 or 2 – Per instructions, “Cross out the paragraph which is not used.”
  - a. If paragraph 2 is selected, one of the following boxes must be checked:
    - i. Premature delivery – indicate the expected date of delivery.
    - ii. Emergency abdominal surgery – describe circumstances.
  - b. Keep in mind that an individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least a full 30 days before the expected date of delivery.
23. Physician’s Signature – Must be the physician who is performing or performed the surgery. This must be the physician’s actual signature. We do not and cannot accept signature stamps.
24. Date – Date the physician signs. We do not and cannot accept date stamps.

**\*\*Note:** Member’s first and last name must match Molina Healthcare of Ohio’s system in order for the consent form to be approved. If the member’s name does not match our records, please advise the member to update his or her name with their County Department of Job and Family Services (CDJFS) Case Worker.

For additional information on sterilization services or information for hysterectomy services, please refer to the [Medicaid Benefits Index section](#) of this appendix.

### ***Surgical Professional Services***

In accordance with [OAC 5160-4-22 Surgical Services](#), physicians must bill using the most comprehensive surgical procedure code(s). This means procedures that are incidental to, or performed as an integral part of, the comprehensive surgical service(s), must not be billed in component parts or "unbundled."

Surgical codes subject to multiple surgery pricing are indicated in [OAC 5160-4-22 Surgical Services - Appendix](#). Multiple surgery pricing will apply to the procedures indicated with an "x" in the corresponding column titled “Multiple Surgery” when multiple surgical procedures are performed on the same patient by the same provider on the same day. These codes should not be billed with multiple units. Billing with more than one unit will result in a denial of that line.

Reimbursement guidelines for surgical codes subject to multiple surgery reduction are as follows:

- 100 percent of the contracted allowable rate for the primary procedure (highest allowable)
- 50 percent of the contracted allowable rate for the secondary procedure
- 25 percent of the contracted allowable rate allowed for all subsequent procedures

### ***Transplants***



In accordance with [OAC 5160-2-03 Conditions and Limitations](#), services related to covered organ donations are reimbursable when the recipient of a transplant is Medicaid-eligible.

Transplant services will be reimbursed according to [OAC 5160-2-07.1 Hospital Services Subject to and Excluded from DRG Prospective Payment](#).

In order to receive reimbursement for organ acquisition charges, the following guidelines are applied:

- The charges must be reported using revenue center code "810 - Organ Acquisition, General Classification." Please note that kidney transplants are not subject to additional reimbursement for organ acquisition.
- The organ recipient must be Medicaid-eligible for acquisition costs to be reimbursed.
  - When both donor and recipient are Medicaid-eligible, the recipient claim must be filed and paid first before submitting the donor claim. The donor claim must have the donor's Medicaid recipient name and ID number on the claim.
  - When the donor is not Medicaid-eligible, the donor's claim must have the Medicaid recipient's name and ID number on the claim.

### *Unlisted Codes*

Molina Healthcare encourages providers to bill with the most accurate and specific CPT or HCPCS code. If an unlisted code is used, documentation is required for all unlisted codes submitted for reimbursement. Documentation should include, but is not limited to:

- Complete description of the unlisted code
- Procedure/operative report for unlisted surgical/procedure code
- Invoice for unlisted DME/supply codes
- NDC number, dose and route of administration for the drug billed

Documentation will be reviewed for appropriate coding and existence of a more appropriate code. Claims submitted with unlisted codes that do not have documentation with them and no prior authorization on file will be denied.

### *Urgent Care Services*

Molina Healthcare requires all services rendered at an urgent care facility be billed with Place of Service 20. This is required for claims to process accurately against urgent care benefits in the Molina Healthcare claims processing system.

## **MyCare Ohio Billing Guidelines**

As stated in the three-way agreement between MCPs, ODM and CMS, Molina Healthcare will offer at minimum all benefits included in Medicare Part A, Part B, and Part D as well as full state plan benefits. Providers should bill in accordance with CMS billing guidelines for all Medicare covered services. For non-Medicare covered services, providers should bill with ODM billing guidelines.

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## *Long Term Care*

### Nursing facilities (NF):

Molina Healthcare follows CMS and ODM billing guidelines for skilled and custodial levels of care. For skilled members, Molina Healthcare reimburses based on current Resource Utilization Groups (RUG) rates. For custodial members, Molina Healthcare will reimburse claims based on the current per diem rate of the facility set forth by ODM. The following services are included in the NF per diem rate and will not be separately reimbursed for custodial members:

- Costs incurred for physical therapy, occupational therapy, speech therapy and audiology services provided by licensed therapists or therapy assistants are reimbursed through the nursing facility per diem.
- Costs incurred for the services of a licensed psychologist are reimbursable through the nursing facility per diem. No reimbursement for psychologist services shall be made to a provider other than the nursing facility, or a community mental health center certified by the ODMHAS.
  - Services provided by an employee of the community mental health center must be billed directly to Molina Healthcare by the community mental health center.
- Costs incurred for physician-ordered administration of aerosol therapy that is rendered by a licensed respiratory care professional are reimbursable through the nursing facility per diem. No reimbursement for respiratory therapy services shall be made to a provider other than the nursing facility through their per diem rate.

### Medicaid bill types:

- Medicaid inpatient claim 213
- Medicaid adjustment claims 217
- Medicaid cancel claims 218

### Medicaid revenue (Rev) codes:

- Regular/full day covered/noncovered day 0101
- Full day: short-term NF stay for waiver consumer 0160
- Therapeutic leave day 0183
- Hospital leave day 0185
- PA1/PA2 flat fee full day 0220
- PA1/PA2 flat fee short-term stay for waiver consumer 0169
- PA1/PA2 flat fee leave day 0189

Other bill types as noted below under Medicare Part A can be used, but these are the most frequent. Religious Nonmedical Health Care Institutions should use bill type 041X.

### SNF Part A bill types:

- Admit through discharge 211
- Interim, first claim 212
- Interim, continuing claim 213
- Final claim 214

- Late charges only claim 215
- Replacement prior claim 217
- Void/cancel prior claim 218

SNF Part B only bill types:

- Admit through discharge 221
- Interim, first claim 222
- Interim, continuing claim 223
- Final claim 224
- Late charges only claim 225
- Replacement prior claim 227
- Void/cancel prior claim 228

SNF outpatient

- Admit through discharge 231
- Interim, first claim 232
- Interim, continuing claim 233
- Final claim 234
- Late charges only claim 235
- Replacement prior claim 237
- Void/cancel prior claim 238

Medicare Part A condition codes

Field 18-28 Required when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. This list of codes including instructions can be found in NUBC UB04 Uniform Billing Manual.

Medicare Part A occurrence codes and occurrence span codes

Field 35-36 Occurrence codes and occurrence span codes are typically used when there is a coordination of benefits. This list of codes and instructions can be found in NUBC UB04 Uniform Billing Manual.

Assisted living services:

The service furnishes 24-hour on-site response capability, personal care, supportive services (homemaker and chore), and the coordination of the provision of three meals a day and snacks.

Nursing and skilled therapy services are incidental, rather than integral, to the provision of the assisted living service. Required nursing services include health assessment and monitoring, medication management including medication administration, and the delivery of part-time intermittent nursing and skilled nursing up to the maximum allowed in [OAC 3701-17-59 Personal Care Services](#) and [3701-17-59.1 Skilled Nursing Care](#), when not available through a third party.

The scope of the service does not include 24-hour skilled care, one-on-one supervision, or the provision of items of comfort or convenience, disposable medical supplies, durable medical equipment, prescription medications or over-the-counter medications.

**Limits:** The service is limited to one unit per calendar day.

Molina Healthcare requires the correct HCPCs and modifier combination billed on every claim. The following chart may be referenced as a guide for billing assisted living waiver claims.

HCPCs Code	Medicaid level of care	Required modifier	Unit increment
<b>T2031</b>	Tier 1	U1	One day
	Tier 2	U2	One day
	Tier 3	U3	One day
<b>T2038</b>	Community transition services	U4	One completed job order

Hospice services:

Effective for dates of service on and after March 1, 2016, hospice providers will not bill directly for hospice room and board (Revenue Code 065X and HCPCs Code T2046). The Nursing Facility (NF) will be responsible for billing room and board and must:

- Bill Molina Healthcare the amount equal to 95 percent of the Medicaid NF or the Intermediate Care Facilities for Individuals with Mental Retardation (ICFMR) per diem rate as obtained from the NF or ICFMR.
- Bill Hospice Room and Board on a UB using Revenue Code 065X along with HCPCS Code T2046, and Molina Healthcare will pay 100 percent of Medicaid for Hospice Room and Board instead of telling the provider to bill 95 percent of their per diem.
- Bill for days the member is in the NF or ICFMR overnight.
- Bill for patients who have elected the hospice under Medicare, but are Medicaid-eligible and reside in a Medicaid-reimbursed NF or ICFMR for the room and board.

When completing the UB04 form for Hospice Room and Board, please complete all required fields. The following fields must be completed with the specific required information noted below:

FL 42 Revenue Code - 0658

Use this field to report the appropriate numeric code corresponding to each narrative description or standard abbreviation that identifies a specific accommodation and/or ancillary service.

UB-04 837I: 5010

Loop (837I only) 2400

Field or data element number and name

#42 Revenue code lines 1-22 SV201 Service line revenue code

Status Required

Length 4 AN 48 AN

Repeatable once per line (See billing tips.)

FL 43 Revenue Description Hospice Service – Hospice Room & Board – Nursing Facility 0658

This field contains a narrative description or standard abbreviation for each revenue code category reported on this claim. This field is also used to report Medicaid drug rebate information or the investigational device exemption (IDE) number for revenue code 0624.

- UB-04 837I: 5010  
Loop (837I only)  
Field or data element number and name  
#43 Revenue description lines 1-22  
SV202-7 Description  
Status Required Situational/ Required  
Length 24 AN 80 AN  
Repeatable once per line; once per service line

FL 44 HCPCS – Hospice Room and Board – T2046

This field contains the Healthcare Common Procedure Coding System (HCPCS) code applicable to ancillary services for outpatient claims, the HIPPS rate code (consisting of the RUG-IV code obtained from the MDS grouper, and a two-digit modifier indicating the assessment type attributable to the RUG-IV code for SNFs, and the HHRGs for home health), or the daily accommodation rate for inpatient bills. It is required for inpatient claims when a drug or biological must be reported with a HCPCS code or when a HIPPS code must be reported for the service line. Accommodation rate is required when a room and board revenue code (RCs100–219) is reported. In the 837I, version 5010, accommodation rates are not reported. The accommodation rate can be determined by dividing the total charge by the number of days.

- UB-04 837I: 5010  
Loop (837I only) 2400  
Field or data element number and name  
#44 HCPCS/ rates/HIPPS rate codes 1-22  
Composite medical procedure Qualifier SV202-1 (See billing tips.) Code SV202-2  
  
Modifiers SV202-3 thru SV202-6 Status Situational  
Length qualifier 2 AN  
Length code 14 AN 48 AN  
Length modifier 2 AN 2 AN  
Repeatable once per line; once per service line

A=alphabetic character N=numeric character AN=alphanumeric character

***Community Behavioral Health Services (BH)***

Behavioral health counseling and therapy services means interaction with a person with the focus on treatment of the person's mental illness or emotional disturbance. When the person served is a child or adolescent, the interaction may also be with the family members and/or parent, guardian and significant others when the intended outcome is improved functioning of the child or adolescent and when such interventions are part of the Individualized Service Plan (ISP). Managed care plans have the potential to improve service coordination, provide greater flexibility in types of services, and help to control costs through reduced reliance on hospitalization and institutionalization for beneficiaries who are mentally ill.

Behavioral health counseling and therapy service shall consist of a series of time-limited, structured sessions that work toward the attainment of mutually defined goals as identified in the ISP. Covered services include:

Community behavioral health:

- Behavioral health counseling – individual and group
- Community psychiatric support treatment – individual and group
- Crisis intervention
- Mental health assessment – physician and non-physician
- Partial hospitalization
- Pharmacological management

Alcohol and other drug treatment services:

- Assessment
- Alcohol drug screening analysis/lab urinalysis
- Care management
- Counseling – individual
- Counseling – group
- Ambulatory detoxification
- Crisis intervention

Providers must bill the unit increments based on the standard CPT/HCPCS coding rules. For 15-minute units, continue to round to the nearest whole unit and for 60-minute units, round to the nearest tenth of a unit (six-minute increments). Medications should be billed in number of units dispensed. A complete [ODMHAS Billing Guide](#) can be found under the [Provider Training section](#) of Molina Healthcare's website at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com).

**Long-Term Services and Supports (LTSS)**

During the TOC period LTSS/waiver services will be need to be billed with the appropriate procedure codes and modifiers based on the legacy/waiver of origin as specified in the OAC. Once the TOC period is over, provider will be required to bill with the appropriate procedure code and modifier combinations for Molina Healthcare's combined waiver. For a complete list of codes and modifier combinations, please refer to the [LTSS Waiver Services Billing Guide](#) found in the [Provider Training section](#) of Molina Healthcare's website at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com).

**Custom Wheelchairs and Wheelchair Repairs**

<b>Billing Requirements</b>					
<b>Lines of business:</b>	<b>Medicare</b>	<b>MMP Medicare</b>	<b>Medicaid</b>	<b>MMP Medicaid</b>	<b>Marketplace</b>
<b>Code(s)/modifier(s):</b>	<b>See applicable Medicare and/or Medicaid fee schedules and the Medicaid Supply List (See link in References below)</b>				
<b>Form type:</b>	<b>HCFA 1500</b>				
<b>Covered service?</b>	<b>Please refer to the applicable Medicare and/or Medicaid fee schedules (See References below)</b>				
<b>Primary explanation of benefit (EOB) required?</b>	<b>No</b>	<b>No</b>	<b>Yes, other than place of service (POS) 31, 32, 33 when Medicare is primary</b>	<b>Yes, other than POS 31, 32, 33</b>	<b>Yes, other than POS 31, 32, 33 when Medicare is primary</b>
<b>Prior authorization (PA) required?</b>	<b>Please refer to the applicable Service Request Form and Instructions and the CPT Codes Requiring Prior Authorization List at <a href="http://www.MolinaHealthcare.com">www.MolinaHealthcare.com</a>.</b>				
<b>Does Medicare apply a cost share?</b>	<b>Yes</b>	<b>Yes</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>
<b>Coordination of benefits (COB) method</b>	<b>N/A</b>	<b>N/A</b>	<b>Lesser of Medicaid maximum or cost share</b>	<b>Lesser of Medicaid maximum or cost share</b>	<b>Lesser of Medicaid maximum or cost share</b>

**Custom Wheelchair Summary: DME Pricing/Invoice Pricing**

In accordance with [Ohio Administrative Code \(OAC\) 5160-10-05 Reimbursement for Covered Services](#), payment for durable medical equipment (DME) – including custom wheelchairs, power wheelchairs and all wheelchair parts and accessories – as well as medical supplies, orthotics or prosthetics, is reimbursed using the following criteria:

- (1) When the item or items appear in [OAC 5160-1-60 Medicaid Payment – Appendix DD](#), the provider shall bill the department the provider's usual and customary charge and will receive the lesser of the usual and customary charge or the Medicaid maximum rate that appears in this appendix; or
- (2) When the item or items do not appear in [OAC 5160-1-60 Medicaid Payment – Appendix DD](#) or appear but without a Medicaid maximum rate and the provider has submitted a list price for payment, the provider shall bill the usual and customary charge and will receive the lesser of the usual and customary charge or 72 percent of the list price; or
- (3) When the item or items in question do not appear in [OAC 5160-1-60 Medicaid Payment – Appendix DD](#) or appear but without a Medicaid maximum rate and the provider has

- submitted an invoice price for payment, the provider shall bill the usual and customary charge and will receive the lesser of the usual and customary charge or 147 percent of the invoice price less any discounts or rebates applicable at the time of billing but exclusive of any discounts or rebates the provider may receive subsequent to the time of billing; or
- (4) In circumstances where paragraph (1), (2) and (3) listed above occur concurrently, the department will reimburse the amount determined to be the most cost effective.
  - (5) The "list price" is defined as the most current price recommended by the manufacturer for retail sale. This price cannot be established nor obscured or deleted by the provider on any documentation supplied for consideration of reimbursement. A provider may set the list price for custom products where the provider is both the manufacturer and the provider so long as the list price is equal to or less than comparable products. Documentation submitted to support this price is subject to approval by the department.
  - (6) The "invoice price" is defined as the price delivered to the consumer and reflects the provider's net costs in accordance with OAC [5160-10-03 Medical Supplies and the Medicaid Supply List](#). This information cannot be obscured or deleted on any documentation supplied for consideration of reimbursement. Documentation submitted to support this price is subject to approval by the department.
  - (7) Costs of delivery and service calls related to DME, medical supplies, orthotics or prosthetics are considered an integral part of the provider's cost of doing business. A charge for these services will not be recognized when billed separately.
  - (8) The consumer must be supplied with the most cost effective DME, medical supply, orthotic or prosthetic that meets his or her clinical needs. Cost effective is defined to mean items which meet the consumer's clinical and lifestyle requirements at the lowest available cost.
  - (9) A supplier of custom items may be reimbursed when the consumer for whom they were intended expires prior to dispensing under the following conditions:
    - a. The Healthcare Common Procedure Coding System (HCPCS) code used to describe the item indicates it is designed or intended for a specific individual; and
    - b. The item cannot be modified for use by another individual; and
    - c. The provider can document measurements of the consumer were taken for fitting prior to the end of life; and
    - d. The provider can document the consumer's health status at the time the item was requested did not indicate the end of life was imminent; and
    - e. The provider uses the date the consumer's measurements were taken as the date of service for the item.

### **Wheelchair Repairs**

Molina Healthcare follows the DME guidelines as referenced in the Ohio Department of Medicaid Supply List and the [List of Orthotic and Prosthetic Procedures](#). It is imperative that appropriate billing be used to identify the services provided and process claims accurately.

- [OAC 5160-10-03 - Appendix A, Medicaid Supply List](#)
  - Follow Molina Healthcare PA requirements
- [OAC 5160-10-20 - Appendix A, List of Orthotic and Prosthetic Procedures](#)
  - Follow Molina Healthcare PA requirements



- [OAC 5160-10-16 Wheelchairs](#)
  - This includes power operated vehicles (POVs). Paragraph (G) gives the coverage and limitations for eligibility of these items.
  - According to paragraph (J)(7), Repair and replacement:
    - A current prescription must be submitted with a request for authorization of a repair when the department did not authorize the purchase of the wheelchair. In this case, a current prescription and documentation of medical necessity must be submitted with the initial request for repair. If the wheelchair is determined to be medically necessary and the repair is authorized, subsequent repairs may be authorized without the submission of a current prescription and documentation of medical necessity.
  - According to paragraph (J) (8), for a consumer who resides in a personal residence, reimbursement may be authorized for the repair of a consumer-owned wheelchair that is not eligible for purchase in accordance with this rule, if it is determined that the wheelchair meets the seating/wheeled mobility needs of the consumer and it would be more cost effective for the department to authorize the repair rather than the replacement of the wheelchair. Authorization for the repair of a wheelchair does not necessarily indicate that the wheelchair would be authorized for purchase. Replacement of any consumer-owned wheelchair will be authorized in accordance with this rule.
- [OAC 5160-10-08 Repair of Medical Equipment](#)
  - According to paragraph (A)(1)(c), providers must submit the appropriate procedure code(s) including modifiers as required for all equipment repair claims submissions and PA requests. For the reimbursement of repairs requiring materials and labor, the appropriate procedure codes must be submitted together on the same claim for the same date of service.
  - According to paragraph (A)(1)(d), all wheelchair and POV repairs must be billed in accordance with [OAC 5160 -10-16 Wheelchairs](#).
    - For the reimbursement of repairs or replacement of parts of wheelchairs without a specific procedure code, use code K0108 modified with the RB modifier in combination with labor code K0739 as appropriate.

## References

- [Medicare Claims Processing Manual](#)
- [Medicare DMEPOS Fee Schedule](#)
- [Medicaid Provider Manual](#) – Please refer to the Claims and Encounter Data section for DME.
- [OAC 5160-10-05 Reimbursement for Covered Services](#)
- [OAC 5160-1-60 Medicaid Payment – Appendix DD](#)

- [OAC 5160-10-03 Medical Supplies and the Medicaid Supply List](#)
- [OAC 5160-10-20 Appendix A, List of Orthotic and Prosthetic Procedures](#)
- [OAC 5160-10-16 Wheelchairs](#)
- [OAC 5160-10-08 Repair of Medical Equipment](#)

## XIV. Appendix B

### Transition of Care Chart

Transition Requirements	HCBS Waiver Beneficiaries	Non-Waiver Beneficiaries with LTC Needs (HH and PDN Use)	NF Beneficiaries AL Beneficiaries	Beneficiaries not Identified for LTC Services
<b>Physician</b>	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others
<b>DME</b>	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity
<b>Scheduled Surgeries</b>	Must honor specified provider	Must honor specified provider	Must honor specified provider	Must honor specified provider
<b>Chemotherapy/Radiation</b>	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider
<b>Organ, Bone Marrow, Hematopoietic Stem Cell Transplant</b>	Must honor specified provider	Must honor specified provider	Must honor specified provider	Must honor specified provider
<b>Dialysis</b>	90 days with same	90 days with same	90 days with same	90 days with same

Transition Requirements	HCBS Waiver Beneficiaries	Non-Waiver Beneficiaries with LTC Needs (HH and PDN Use)	NF Beneficiaries AL Beneficiaries	Beneficiaries not Identified for LTC Services
<b>Treatment</b>	provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.	provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.	provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.	provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.
<b>Vision and Dental</b>	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered
<b>Medicaid Home Health and PDN</b>	Maintain service at current level and with current providers at current Medicaid reimbursement rates. Changes may not occur unless:  A significant change occurs as defined in OAC 5160-45-01; or Individuals expresses a desire to self-direct services; or after 365 days.	Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation	For AL: Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation	N/A
<b>Assisted Living Waiver Service</b>			Provider maintained at current rate for the life of Demonstration.	
<b>Medicaid Nursing Facility Services</b>			Provider maintained at current Medicaid rate for the life of	

Transition Requirements	HCBS Waiver Beneficiaries	Non-Waiver Beneficiaries with LTC Needs (HH and PDN Use)	NF Beneficiaries AL Beneficiaries	Beneficiaries not Identified for LTC Services
			Demonstration.	
<b>Waiver Services-Direct Care</b> <b>Personal Care Waiver</b> <b>Nursing Home Care</b> <b>Attendant Choice Home Care</b> <b>Attendant Out of Home Respite</b> <b>Enhanced Community Living</b> <b>Adult Day Health Services</b> <b>Social Work Counseling</b> <b>Independent Living Assistance</b>	Maintain service at current level and with current providers at current Medicaid reimbursement rates. Plan initiated changes may not occur unless:  A significant change occurs as defined in OAC 5160-45-01 ; or individual expresses a desire to self-direct services; or after 365 days.	N/A	N/A	N/A
<b>Waiver Services-All other</b>	Maintain service at current level for 365 days and existing service provider at existing rate for 90 days. Plan initiated change in service provider can only occur after an in-home assessment and plan for the transition to a new provider.	N/A	N/A	N/A
<b>Medicaid</b>	Maintain current	Maintain current	Maintain current	Maintain current

Transition Requirements	HCBS Waiver Beneficiaries	Non-Waiver Beneficiaries with LTC Needs (HH and PDN Use)	NF Beneficiaries AL Beneficiaries	Beneficiaries not Identified for LTC Services
<b>Community Behavioral Health Organizations (Provider types 84 &amp; 95).</b>	provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.	provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.	provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.	provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.