Provider Manual

(Provider Handbook)

Molina Healthcare of Florida, Inc.

(Molina Healthcare or Molina)

Medicaid

2025

Capitalized words or phrases used in this Provider Manual shall have the meaning set forth in your Agreement with Molina Healthcare. "Molina Healthcare" or "Molina" has the same meaning as "Health Plan" in your Agreement. The Provider Manual is customarily updated annually but may be updated more frequently as needed. Providers can access the most current Provider Manual at MolinaHealthcare.com.

Material in this manual is subject to change. Updates will be communicated through provider alerts and posted online. Please visit Molinahealthcare.com for the most up-to-date information.

If you are interested in participating with Molina, please visit Molinahealthcare.com, or call Provider Services at (855) 322-4076.

Last Updated: 04/2025

MOLINA® HEALTHCARE

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Welcome to Molina Healthcare of Florida's Statewide Medicaid Managed Care Plan

Welcome to our provider network serving the Medicaid Managed Care (SMMC) Program. Molina Healthcare offers services for enrollees in Managed Medical Assistance (MMA), Long-Term Care (LTC) HIV, and SMI Specialty, in Miami-Dade and Monroe counties in Florida.

As a provider, you play a critical role in the success of our health plan and serving our members in Miami-Dade and Monroe Counties.

This manual will be your guide to all health care services we offer. Our manual is also located on MolinaHealthcare.com. To request a printed copy of this manual, please call provider services at (855) 322-4076, and we will be happy to send you a copy.

If there are material changes to the provider manual, we will make every effort to notify you in advance of the changes through our website, fax communications and our provider portal.

This manual is not intended to be a complete statement of all policies and procedures. We may publish other policies and procedures that are not included via our website or provider portal.

1. Contact information

Molina Healthcare of Florida, Inc.
8300 NW 33rd Street, Suite 400
Doral, FL 33122

Provider services

The Molina Provider Contact Center handles telephone and written inquiries from Providers regarding Claims, appeals, authorizations, eligibility and general concerns. Molina Provider Contact Center representatives are available 8:00 AM to 7:00 PM EST Monday through Friday, excluding state and federal holidays.

Molina strongly encourages participating Providers to submit Claims electronically via a clearinghouse or the Availity Essentials (Availity) portal whenever possible.

EDI Payer ID Number: 51062

To verify the status of your Claims please use the Availity portal. Claims questions can be submitted through the Secure Messaging feature via the Claim Status module on the Availity portal, or by contacting the Molina Provider Contact Center.

Eligibility verifications can be conducted at your convenience via the Eligibility and Benefits module on the Availity portal.

Phone: (855) 322-4076
Fax: (866) 948-3537
Availity portal: provider.MolinaHealthcare.com
Hearing Impaired (TTY/TDD): 711

Provider relations

The Provider Relations department manages issue resolution, Provider education and training. The department has Provider Relations representatives who serve all of Molina's Provider network. Visit the Contact Us page on our website to download a list of contact information for Molina's Provider Relations representatives.

Member services

The Molina Member Contact Center handles all telephone inquiries regarding benefits, eligibility/identification, pharmacy inquiries, selecting or changing primary care providers (PCP) and Member complaints. Molina Member Contact Center representatives are available 8:00 AM to 7:00 PM EST Monday through Friday, excluding state and federal holidays.

Phone: (866) 472-4585
Hearing Impaired (TTY/TDD): 711
Automated Voice Response System (AVRS): (800) 239-7560

Claims

Molina strongly encourages participating Providers to submit Claims electronically via a clearinghouse or Availity portal whenever possible.

- Availity portal
- EDI Payer ID 51062

To verify the status of your Claims, please use the Availity portal. Claims questions can be submitted through the Secure Messaging feature via the Claim Status module on the Availity portal or by contacting the Molina Provider Contact Center. For

additional information please refer to the **Claims and Compensation** section of this Provider Manual.

Claims recovery

The Claims Recovery department manages recovery for overpayment and incorrect payment of Claims.

In accordance with 42 CFR 438.608(d)(2), Providers should notify Molina within 60 days of identifying receipt of an overpayment. You can submit your refund and overpayment notice to Molina, ensuring it includes member name, member ID, claim number, date(s) of service and overpayment amounts.

Provider disputes	Molina Healthcare of Florida, Inc. Claims Recovery Department PO Box 2470 Spokane, WA 99210-2470
Refund checks lockbox	Refund Checks Lockbox Molina Healthcare of Florida PO Box 741037 Atlanta, GA 30374-1037
Phone:	(866) 642-8999

Compliance and fraud alertline

Suspected cases of fraud, waste or abuse must be reported to Molina. You may do so by contacting the Molina Alertline or by submitting an electronic complaint using the website listed below. For additional information on fraud, waste and abuse please refer to the **Compliance** section of this Provider Manual.

Confidential
Compliance Official
Molina Healthcare, Inc.
200 Oceangate
Suite 100
Long Beach, CA 90802

Phone: (866) 606-3889
Online: MolinaHealthcare.Alertline.com

Credentialing

The Credentialing department verifies all information on the Provider Application prior to contracting and re-verifies this information every three (3) years or sooner depending on Molina's credentialing criteria. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Molina network. For additional information about Molina's credentialing program please refer to the Credentialing and Recredentialing section of this Provider Manual.

24-hour Nurse Advice Line

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

Health care services

The Healthcare Services department conducts concurrent review on inpatient cases and processes Prior Authorization requests. The Healthcare Services (HCS) department also performs Care Management for Members who will benefit from Care Management services. Participating Providers must interact with Molina's HCS department electronically when possible. Prior Authorizations/Service Requests and status checks can be easily managed electronically.

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

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

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

- Submit requests via 278 transactions. See the EDI transaction section of Molina's website for guidance
- Availity portal
- Phone: (855) 322- 4076

- Prior Authorizations Fax: (866) 440-9791
- Advanced imaging: (877) 731-7218
- Transplants: (877) 813-1206

Health management

Molina provides health management programs designed to assist Members and their families to better understanding their chronic health condition(s) and adopting healthy lifestyle behaviors. Phone: (866) 891-2320.

Fax: (800) 642-3691

Behavioral health

Molina manages all components of covered services for behavioral health. For Member behavioral health needs, please contact us directly at (855) 322-4076. Molina has a Behavioral Health Crisis Line that Members may access 24 hours per day, 365 days per year by calling the Member Services telephone number on the back of their Molina ID card. For additional information please refer to the **Behavioral Services** section of this Provider Manual.

Pharmacy

The State (AHCA) preferred drug list requires Prior Authorization for certain medications including injectable medications. The Pharmacy department can answer questions regarding the formulary and/or drug Prior Authorization requests. They will also facilitate the services of CVS Caremark Pharmacy Services for injectable medications. The formulary is available on the Florida Medicaid Preferred Drug List (PDL) (myflorida.com). A list of in-network pharmacies is available on the Molina website or by contacting Molina. For additional information please refer to the **Pharmacy** section of this Provider Manual.

Phone: (855) 322-4076
Pharmacy Prior Authorization Fax: (866) 236-8531

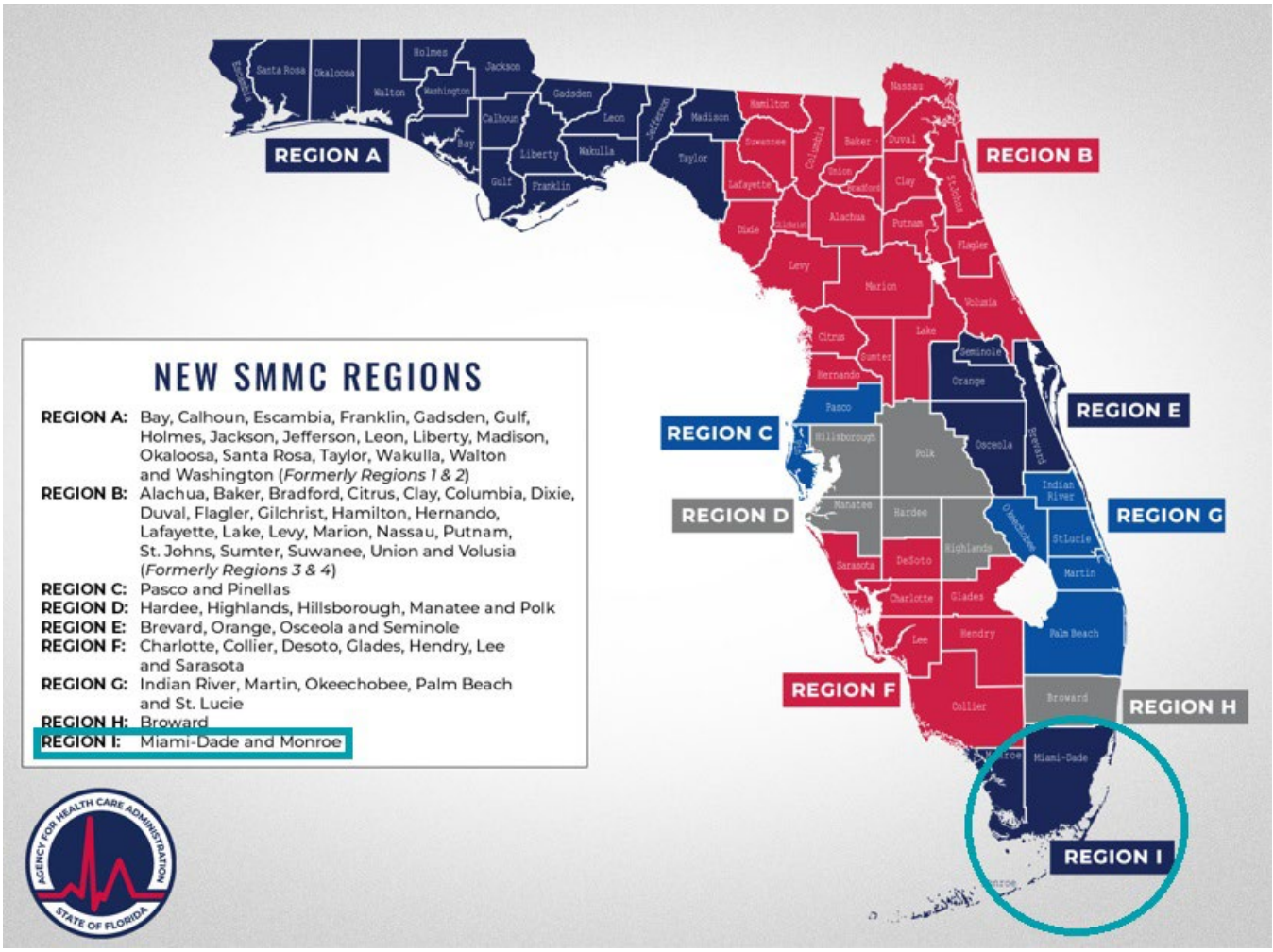
Quality

Molina maintains a Quality department to work with Members and Providers in administering the Molina Quality Improvement (QI) Program. For additional information please refer to the **Quality** section of this Provider Manual.

Phone: (855) 322-4076

Fax: (866) 948-3537

Molina Healthcare of Florida service area



2. Provider responsibilities

Non-discrimination in health care service delivery

Providers must comply with the nondiscrimination of health care service delivery requirements as outlined in the **Cultural Competency and Linguistic Services** section of this Provider Manual.

Additionally, Molina requires Providers to deliver services to Molina Members without regard to the source of payment. Specifically, Providers may not refuse to serve Molina Members because they receive assistance with cost-sharing from a government-funded program.

Providers serving Medicaid Members are required to maintain the same hours of operation as those offered to commercial benefit Members.

Section 1557 Investigations

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

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

Phone: (866) 606-3889
TTY/TDD: 711
Online: MolinaHealthcare.AlertLine.com
Email: civil.rights@MolinaHealthcare.com

For additional information, you can refer to the Health and Human Services website (HHS) at federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

Facilities, equipment, personnel and administrative services

The Provider's facilities, equipment, personnel, and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all

applicable legal requirements including the accessibility requirements of the Americans with Disabilities Act (ADA).

Provider data accuracy and validation

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

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement and an NCQA required element. Invalid information can negatively impact Member access to care, Member/PCP assignments and referrals. Additionally, current information is critical for timely and accurate Claims processing.

Providers must validate their Provider information on file with Molina at least once every 90 days for correctness and completeness.

Additionally, in accordance with the terms specified in the Provider Agreement, Providers must notify Molina of any changes as soon as possible but at a minimum of 30 calendar days in advance of any changes in any Provider information on file with Molina. Changes include, but are not limited to:

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

For Provider terminations (within an existing clinic/practice), Providers must notify Molina in writing in accordance with the terms specified in your Provider Agreement with Molina.

Please visit our Provider Online Directory at MolinaProviderDirectory.com/FL to validate your information. Providers can make updates through the mflproviderservicesmanagement@molinahealthcare.com mailbox, or you may submit a full roster that includes the required information above for each healthcare Provider and/or healthcare facility in your practice.

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

Molina is required to audit and validate our Provider network data and Provider directories on a routine basis. As part of our validation efforts, we may reach out to our network of Providers through various methods, such as letters, phone campaigns, face-to-face contact, fax and fax-back verification, etc. Molina also may use a vendor to conduct routine outreach to validate data that impacts the Provider directory or otherwise impacts membership or ability to coordinate Member care. Providers are required to supply timely responses to such communications.

All Molina Providers participating in a Medicaid network must be enrolled in the Statewide Medicaid Managed Care program to be eligible for reimbursement. If a Provider has not had a Medicaid number assigned, the Provider must apply for enrollment with the Florida Agency for Health Care Administration and meet the Medicaid Provider enrollment requirements.

National Plan and Provider Enumeration System (NPPES) data verification

In addition to the above verification requirements, CMS recommends that Providers routinely verify and attest to the accuracy of their National Plan and Provider Enumeration System (NPPES) data.

NPPES allows Providers to attest to the accuracy of their data. If the data is correct, the Provider is able to attest, and NPPES will reflect the attestation date. If the information is not correct, the Provider is able to request a change to the record and attest to the changed data, resulting in an updated certification date.

Molina supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. Additional information regarding the use of NPPES is available in the Frequently Asked Questions (FAQ) document published at the following link: cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.

Molina electronic solutions requirements

Molina requires Providers to utilize electronic solutions and tools whenever possible.

Molina requires all contracted Providers to participate in and comply with Molina's Electronic Solution Requirements, which include, but are not limited to, electronic submission of prior authorization requests, prior authorization status inquiries, health plan access to electronic medical records (EMR), electronic Claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic Claims Appeal and registration for and use of the Availity portal.

Electronic Claims include Claims submitted via a clearinghouse using the EDI process and Claims submitted through the Availity portal.

Any Provider entering the network as a Contracted Provider will be required to comply with Molina's Electronic Solution Policy by enrolling for EFT/ERA payments and registering for the Availity portal within 30 days of entering the Molina network.

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

Electronic solutions/tools available to providers

Electronic solutions/tools available to Molina Providers include:

- Electronic Claims Submission Options
- Electronic Payment: EFT with ERA
- Availity portal

Electronic Claims submission requirement

Molina strongly encourages participating Providers to submit Claims electronically whenever possible. Electronic Claims submission provides significant benefits to the Provider, including:

- Promotes HIPAA compliance
- Helps to reduce operational costs associated with paper Claims (printing, postage, etc.)
- Increases accuracy of data and efficient information delivery
- Reduces Claim delays since errors can be corrected and resubmitted electronically
- Eliminates mailing time and Claims reach Molina faster

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the Availity portal.
- Submit Claims to Molina through your EDI clearinghouse using Payer ID 51062, refer to our website MolinaHealthcare.com for additional information.

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

Availity portal Claim submission includes the ability to:

- Add attachments to Claims
- Submit corrected Claims
- Easily and quickly void Claims
- Check Claim status
- Receive timely notification of a change in status for a particular Claim
- Ability to save incomplete/un-submitted Claims
- Create/manage Claim templates

For additional information on EDI Claim submission and Paper Claim submission please refer to the **Claims and Compensation** section of this Provider Manual.

Electronic payment requirement

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

Participating Providers are required to enroll in EFT and ERA. Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services give Providers the ability to reduce paperwork, utilize searchable ERAs and receive payment and ERA access faster than the paper check and remittance advice (RA) processes. There is no cost to the Provider for EFT enrollment and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA-compliant EFT payment and ERA delivery processes.

Molina has partnered with ECHO Health, Inc. (ECHO), for payment delivery and 835 processing. On this platform, you may receive your payment via EFT/Automated Clearing House (ACH), a physical check or a virtual card.

By default, if you have no payment preferences specified on the ECHO platform, your payments will be issued via virtual card. This method may include a fee that is established between you and your merchant agreement and is not charged by Molina or ECHO. You may opt out of this payment preference and request payment be reissued at any time by following the instructions on your explanation of payment (EOP) and contacting ECHO customer service at (888) 834-3511 or edi@echohealthinc.com. Once your payment preference has been updated, all payments will go out in the method requested.

If you would like to opt out of receiving a virtual card prior to your first payment, you may contact ECHO Customer Service at (888) 834-3511 or edi@echohealthinc.com and request that your Tax ID for payer Molina Healthcare of Florida be opted out of virtual cards.

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

If you have any difficulty with the website or have additional questions, ECHO has a customer services team available to assist with this transition. Additionally, changes to the ERA enrollment or ERA distribution can be made by contacting the ECHO customer services team at (888) 834-3511.

As a reminder, Molina's Payer ID is 51062.

Once your account is activated, you will begin receiving all payments through EFT and you will no longer receive a paper EOP (i.e., remittance) through the mail. You will receive 835s (by your selection of routing or via manual download) and can view, print, download and save historical and new ERAs with a two (2)-year lookback.

Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina's website at MolinaHealthcare.com.

Availity portal

Providers and third-party billers can use the no cost Availity portal to perform many functions online without the need to call or fax Molina. Registration can be performed online and once completed the easy-to-use tool offers the following features:

- Verify Member eligibility, covered services and view Healthcare Effectiveness Data and Information Set (HEDIS®) needed services (gaps)
- Claims:
  - Submit Professional (CMS1500) and Institutional (UB04) Claims with attached files
  - Correct/Void Claims
  - Add attachments to previously submitted Claims
  - Check Claims status
  - View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
  - Create and manage Claim Templates
  - Create and submit a Claim Appeal with attached files
- Prior Authorizations/Service Requests
  - Create and submit Prior Authorization/Service Requests
  - Check status of Authorization/Service Requests
- Download forms and documents
- Send/receive secure messages to/from Molina

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

Balance billing

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

The Provider agrees that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. Balance billing a member for services covered by Molina is prohibited, except for the Member's applicable copayment, coinsurance, and deductible amounts.

Member rights and responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in Member materials (such as Member Handbooks).

For additional information please refer to the Member Rights and Responsibilities section of this Provider Manual.

Member information and marketing

Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all State and Federal Laws and regulations and be approved by Molina prior to use.

Please contact their Provider Relations representative for information and a review of proposed materials.

Member eligibility verification

Possession of a Molina ID Card does not guarantee Member eligibility or coverage. Providers should verify eligibility of Molina Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

Providers who contract with Molina may verify a Member's eligibility by checking the following:

- Availity
- Molina Provider Services automated IVR system at (855) 322-4076

For additional information please refer to the Enrollment, Eligibility, and Disenrollment section in this Provider Manual.

Member cost share

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

Health care services (utilization management and care management)

Providers are required to participate in and comply with Molina's Utilization Management and Care Management programs, including all policies and procedures regarding Molina's facility admission, prior authorization, and Medical Necessity review

determination procedures. Providers will also cooperate with Molina in audits to identify, confirm, and/or assess utilization levels of covered services.

For additional information please refer to the Health Care Services section of this Provider Manual.

In-office laboratory tests

Molina's policies allow only certain lab tests to be performed in a Provider's office regardless of the line of business. All other lab testing must be referred to an In-Network Laboratory Provider that is a certified, full-service laboratory, offering a comprehensive test menu that includes routine, complex, drug, genetic testing, and pathology. A list of those lab services that are allowed to be performed in the Provider's office is found on the Molina website at MolinaHealthcare.com.

Additional information regarding In-Network Laboratory Providers and In-Network Laboratory Provider patient service centers is found on the laboratory Providers' respective websites at appointment.questdiagnostics.com/patient/confirmation and labcorp.com/labs-and-appointments.

Specimen collection is allowed in a Provider's office and shall be compensated in accordance with your agreement with Molina and applicable State and Federal billing and payment rules and regulations.

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

Referrals

A referral may become necessary when a Provider determines medically necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals unless the situation is one involving the delivery of Emergency Services. Information is to be exchanged between the PCP and specialist to coordinate care of the patient to ensure continuity of care. Providers need to document referrals that are made in the patient's medical record. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

Providers should direct Molina Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed (if applicable) with Molina. In the case of urgent and Emergency Services, Providers may direct

Members to an appropriate service including, but not limited to, primary care, urgent care, and hospital emergency room. There may be circumstances in which referrals may require an out of network Provider. Prior authorization will be required from Molina except in the case of Emergency Services (please refer to the Health Care Services section of this Provider Manual).

Referrals are not required for visits to Providers with the following specialties - Obstetrics and Gynecology, Dermatology, Chiropractic, Behavioral Health, and Podiatry. Members may access these specialties directly.

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

Providers are educated on Molina's services that are outside the scope of covered services. Expanded benefits and in lieu of services play a vital role in enhancing enrollee outcomes. Providers are also educated on the availability of Molina's Help Finder services to locate non-covered services to assist with resolving social determinants of health.

For additional information please refer to the Health Care Services section of this Provider Manual.

Treatment alternatives and communication with Members

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

Pharmacy program

Providers are required to adhere to the AHCA preferred drug list and prescription policies/criteria. For additional information please refer to the Pharmacy section of this Provider Manual.

Participation in Quality (QI) programs

Providers are expected to participate in Molina's Quality Programs and collaborate with Molina in conducting peer review and audits of care rendered by Providers. Such participation includes, but is not limited to:

- Access to Care Standards
- Site and Medical Record-Keeping Practice Reviews as applicable
- Delivery of patient care information

For additional information, please refer to the Quality section of this Provider Manual.

Compliance

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

Confidentiality of Member health information and HIPAA transactions

Molina requires that Providers respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member protected health information. For additional information, please refer to the Compliance section of this Provider Manual.

Participation in grievance and appeals programs

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

For additional information, please refer to the Complaints, Grievance and Appeals Process section of this Provider Manual.

Participation in credentialing

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

Providers must notify Molina no less than 30 days in advance when they relocate or open an additional office.

For additional information on Molina's credentialing program, please refer to the Credentialing and Recredentialing section of this Provider Manual.

Delegation

Delegated entities must comply with the terms and conditions outlined in Molina's Delegated Services Addendum. Please see the Delegation section of this Provider Manual for more information about Molina's delegation requirements and delegation oversight.

Primary Care provider responsibilities

PCPs are responsible to:

- Serve as the ongoing source of primary and preventive care for Members
- Assist with coordination of care as appropriate for the Member's health care needs
- Recommend referrals to specialists participating with Molina
- Triage appropriately
- Notify Molina of Members who may benefit from Care Management
- Participate in the development of Care Management treatment plans

3. Cultural competency and linguistic services

Background

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services.

Molina complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency (LEP) and Members who are deaf, hard of hearing, non-verbal, have a speech impairment, or have an intellectual disability.

Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, genders, gender identities, sexual orientations, ages, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at MolinaHealthcare.com, from your local Provider Services representative and by calling Molina Provider Services at (855) 322-4076.

Non-discrimination in health care service delivery

Molina complies with Section 1557 of the ACA. As a Provider participating in Molina's Provider Network, you and your staff must also comply with the nondiscrimination provisions and guidance set forth by the Department of Health and Human Services, Office for Civil Rights (HHS-OCR); State law; and Federal program rules, including Section 1557 of the ACA.

You are required to do, at a minimum, the following:

1. You MAY NOT limit your practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.
2. You MUST post in a conspicuous location in your office, a Nondiscrimination Notice. A sample of the Nondiscrimination Notice that you will post can be found in the Member Handbook located at MolinaHealthcare.com.
3. You MUST post in a conspicuous location in your office, a Tagline Document, that explains how to access non-English language services. A sample of the Tagline Document that you will post can be found in the Member Handbook located at MolinaHealthcare.com.
4. If a Molina Member is in need of language assistance services while at your office, and you are a recipient of Federal Financial Assistance, you MUST take reasonable steps to make your services accessible to persons with limited English proficiency ("LEP"). You can find resources on meeting your LEP

obligations at hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html; See also, hhs.gov/civil-rights/for-providers/clearance-medicare-providers/technical-assistance/limited-english-proficiency/index.html.

5. If a Molina Member complains of discrimination, you MUST provide them with the following information so that they may file a complaint with Molina's Civil Rights Coordinator or the HHS-OCR:

Civil Rights Coordinator Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802 Phone (866) 606-3889 TTY/TDD, 711 civil.rights@MolinaHealthcare.com	Office of Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 Website: ocrportal.hhs.gov/ocr/smartscreen/main.jsf Complaint Form: hhs.gov/ocr/complaints/index.html

If you or a Molina Member needs additional help or more information, call (800) 368-1019 or TTY/TDD (800) 537-7697.

Cultural competency

Molina is committed to reducing health care disparities. Training employees, Providers and their staff, and quality monitoring are the cornerstones of successful, culturally competent service delivery. Molina integrates cultural competency training into the overall Provider training and quality-monitoring programs. An integrated quality approach enhances the way people think about our Members, service delivery and program development so that cultural competency becomes a part of everyday thinking.

Provider and community training

Molina offers educational opportunities in cultural competency concepts for Providers, their staff, and Community Based Organizations. Molina conducts Provider training

during Provider orientation, with annual reinforcement training offered through Provider Services and/or online/web-based training modules.

Training modules, delivered through a variety of methods, include:

1. Provider written communications and resource materials.
2. On-site cultural competency training.
3. Online cultural competency Provider training modules.
4. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications.

Integrated quality improvement

Molina ensures Member access to language services such as oral interpretation, American Sign Language (ASL), and written translation. Molina must also ensure access to programs, aids, and services that are congruent with cultural norms. Molina supports Members with disabilities and assists Members with LEP.

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

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

Access to interpreter services

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Contact Center toll free at (866) 472-4585, or for hearing impaired, 711 to make an appointment with a qualified interpreter. If Contact Center Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the Member to a qualified language service Provider.

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

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

An individual with LEP 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 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 individuals with cognitive impairments
- Be notified by the medical Provider that interpreter services are available at no cost
- 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 Member records
    - Interpreters may, with Member written consent, share information from the Member's records only with appropriate medical professionals and agencies working on the Member'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.
When Molina Members need an 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 Member that an interpreter, limited hearing, and/or limited reading services are available
- Molina is available to assist Providers with locating these services if needed:

- Providers needing assistance finding onsite interpreter services
- Providers needing assistance finding translation services
- Providers with Members who cannot hear or have limited hearing ability may use the National TTY/TDD relay service at 711
- Providers with Members with limited vision may contact Molina for documents in large print, Braille or audio version
- Providers with Members with limited reading proficiency LRP; The Molina Contact Center representative will verbally explain the information, up to and including reading the documentation to the Members or offer the documents in audio version

Documentation

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

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

Members who are deaf or hard of hearing

Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to the Molina Member & Provider Contact Center, quality, health care services, and all other health plan functions.

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

Molina will provide face-to-face service delivery for ASL to support our Members who are deaf or hard of hearing. Requests should be made three business days before an

appointment to ensure service availability. In most cases, Members will have made this request via Molina Member Services.

24-hour Nurse Advice Line

Molina provides Nurse Advice services for Members 24 hours per day, seven days per week. The Nurse Advice Line provides access to 24-hour interpretive services. Members may call Molina's Nurse Advice Line directly:

HEALTHLINE 24-Hour Nurse Advice Line
English Phone: (888) 275-8750 Spanish Phone: (866) 648-3537
TTY: (866) 735-2929 or 711 (English) (866) 833-4703 (Spanish)

The Nurse Advice Line telephone numbers are also printed on Molina Member ID cards.

Program and Policy Review Guidelines

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

- Annual collection and analysis of race, ethnicity and language data from:
  - Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's membership.
  - Contracted Providers to assess gaps in network demographics.
- Revalidate data at least annually.
- Local geographic population demographics and trends derived from publicly available sources (Community Health Measures and State Rankings Report).
- Applicable national demographics and trends derived from publicly available sources.
- Assessment of Provider Network.
- Collection of data and reporting for the Diversity of Membership HEDIS® measure.
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations.

- Analysis of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

4. Member rights & responsibilities

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Member Handbook and on the Molina website. The Member Handbook provided to Members annually is hereby incorporated into this Provider Manual. The most current Member Rights and Responsibilities can be accessed via the following link:
MolinaHealthcare.com/providers/fl/medicaid/policies/member_rights.aspx.

Member Handbooks are available on Molina's Member Website. Member Rights and Responsibilities are outlined under the heading "Your Rights and Responsibilities" within the Member Handbook document.

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

For additional information, please contact Molina at (855) 322-4076, M-F 8:00 am – 7:00 pm. TTY/TDD users, please call 711.

Second opinions

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

5. Enrollment, eligibility, disenrollment

Enrollment in Medicaid Programs

Medicaid is the medical assistance program authorized by Title XIX of the Social Security Act, 42U.S.C. §1396 et seq., and regulations thereunder, as administered in the

State of Florida by the Agency for Healthcare Administration under s. 409.901 et seq., F.S. It is the state and federal system of health insurance that provides health coverage for eligible children, seniors, disabled adults, and pregnant women.

The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, F.S.) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. This program is referred to as Statewide Medicaid Managed Care (SMMC) and includes two programs: one for Managed Medical Assistance (MMA) and one for Long-Term Care (LTC).

The State of Florida (State) has the sole authority for determining eligibility for Medicaid. The Department of Children and Families acts as the Agency's agent by enrolling recipients in Medicaid. The agency shall have the sole authority for determining whether Medicaid recipients are required to enroll in, may volunteer to enroll in, may not enroll in a Managed Care Plan or are subject to annual open enrollment. The Agency or its agent(s) shall be responsible for enrollment, including algorithms to assign mandatory potential enrollees, and disenrollment, including determinations regarding involuntary disenrollment, in accordance with this Contract.

The Agency shall be responsible for the operations of the Florida Medicaid Management Information System (FMMIS) and contracting with the state's fiscal agent to exchange data with Managed Care Plans, enroll Medicaid providers, process Medicaid claims, distribute Medicaid forms and publications, and send written notification and information to all potential enrollees.

Only Medicaid recipients who meet eligibility requirements and are living in a region with authorized Managed Care Plans are eligible to enroll and receive services from the Managed Care Plan. Each recipient shall have a choice of Managed Care Plans and may select any authorized Managed Care Plan unless the Managed Care Plan is restricted to a specific population that does not include the recipient.

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

Medicaid recipients who qualify and become enrolled in the Florida Long-Term Care Managed Care Program will receive long-term care services managed through a case manager of the health plan. The health plan will work with different providers to offer

quality health care services and to ensure enrollees have access to covered services as needed.

The Managed Care Plan may not impose enrollment fees, premiums, or similar charges on Indians served by an Indian health care provider; Indian Health Service; an Indian Tribe, Tribal Organization, or Urban Indian Organization; or through referral under contract health services, in accordance with the American Recovery and Reinvestment Act of 2009.

The Agency or its agents will notify the Managed Care Plan of an enrollee's selection or assignment to the Managed Care Plan. The Agency or its enrollment broker will send written confirmation to enrollees of the chosen or assigned Managed Care Plan. Notice to the enrollee will be sent by surface mail. Notice to the Managed Care Plan will be by file transfer.

Recipients in any of the following programs or eligibility categories are required to enroll in a Managed Care Plan:

1. Temporary Assistance to Needy Families (TANF)
2. SSI (Aged, Blind and Disabled)
3. Hospice
4. Low Income Families and Children
5. Institutional Care
6. Medicaid (MEDS) - Sixth Omnibus Budget Reconciliation Act (SOBRA) for children age 18 to 19
7. MEDS AD (SOBRA) for aged and disabled
8. Protected Medicaid (aged and disabled)
9. Full Benefit Dual Eligibles (Medicare and Medicaid -FFS)
10. Full Benefit Dual Eligibles enrolled in Part C – Medicare Advantage Plans that are not fully liable for all Medicaid services covered under the current SMMC Contract
11. The Florida Assertive Community Treatment Team (FACT Team)
12. Title XXI MediKids
13. Children between 100 - 133% of federal poverty level (FPL) who transfer from the state's Children's Health Insurance Program (CHIP) to Medicaid MEDS (SOBRA) for children under one year old and income between 185 - 200% FPL

Voluntary enrollment

Certain recipients may voluntarily enroll in a Managed Care Plan to receive services. These recipients are not subject to mandatory open enrollment periods.

Excluded populations

Certain Medicaid recipients are not eligible to enroll in a Medicaid Managed Care Plan and are referred to as excluded populations.

Enrollment and eligibility for home & community based services

Eligible recipients age 18 years or older in any of the following programs or eligibility categories are required to enroll in a Managed Care Plan if they have been determined by CARES to meet the nursing facility level of care:

1. Temporary Assistance to Needy Families (TANF)
2. SSI (Aged, Blind and Disabled)
3. Institutional Care
4. Hospice
5. Individuals who age out of Children's Medical Services and meet the following criteria:
    (a) Received care from Children's Medical Services prior to turning age 21 years
    (b) Age 21 years and older
    (c) Cognitively intact
    (d) Medically complex
    (e) Technologically dependent
6. Low Income Families and Children
7. MEDS (SOBRA) for children born after 9/30/83 (age 18 through 20 years)
8. MEDS AD (SOBRA) for aged and disabled
9. Protected Medicaid (aged and disabled)
10. Full Benefit Dual Eligibles (Medicare and Medicaid)
11. Individuals enrolled in the Frail/Elderly Program component of United Healthcare HMO
12. Medicaid Pending for Long-term Care Managed Care HCBS waiver services

Members with serious mental illness (SMI)

Molina's Medicaid recipients ages six and older in treatment for a serious mental illness (SMI). SMI members are considered members who are ages six and older with a general descriptor for one, or a combination of the following diagnostic categories: psychotic

disorders, bipolar disorder, major depression, schizophrenia, delusional disorder, or obsessive-compulsive disorder.

Effective date of enrollment

The Agency or its agents will notify the Managed Care Plan of an enrollee's selection or assignment to the Managed Care Plan. Notice to the enrollee will be sent by surface mail. Notice to the Managed Care Plan will be by file transfer. Enrollment in the Managed Care Plan shall be effective at 12:01 a.m. on the effective date of enrollment provided on the Enrollment File.

For MMA Managed Care Plans, if the enrollee has not chosen a PCP, the Agency's confirmation notice will advise the enrollee that a PCP will be assigned by the Managed Care Plan.

Conditioned on continued eligibility, mandatory Members will have a lock-in period of up to 12 consecutive months. After an initial 120-day change period, mandatory Members will only be able to disenroll from the Health Plan for cause. The Agency or its enrollment broker will notify Members at least once every 12 months and at least 60 calendar days prior to the date the lock-in period ends that an open enrollment period exists giving them the opportunity to change Managed Care Plans. Mandatory Members who do not make a change during open enrollment will be deemed to have chosen to remain with the current Managed Care Plan unless that Managed Care Plan no longer participates. In that case, the Member will be transitioned to a new Managed Care Plan.

Enrollment in a Managed Care Plan may be effective on the first calendar day of the month following an approved plan change.

The Agency will automatically reinstate an enrollee into the Managed Care Plan in which the person was most recently enrolled if the enrollee has a temporary loss of eligibility. In this instance, for mandatory Members, the lock-in period will continue as though there had been no break in eligibility, keeping the original 12-month period. For MMA Managed Care Plans, the "temporary loss period" is defined as no more than 180 calendar days. If a temporary loss of eligibility causes the enrollee to miss the open enrollment period, the Agency will enroll the person in the Managed Care Plan in which he or she was enrolled before loss of eligibility. The enrollee will have 120 calendar days from enrollment to disenroll without cause.

Newborn enrollment

Molina shall be responsible for newborns of pregnant enrollees from the date of their birth. The Managed Care Plan shall comply with all requirements and procedures set forth by the Agency or its agent related to unborn activation and newborn enrollment.

Failure to comply with the procedures, set forth by the Agency or its agent, related to the unborn activation and newborn enrollment process as specified by the Agency, may result in sanctions.

Newborns are enrolled in the Managed Care Plan of the mother unless the mother chooses another plan, or the newborn does not meet the enrollment criteria of the mother's plan. When a newborn does not meet the criteria of the mother's plan, the newborn will be enrolled in a plan in accordance with MMA guidelines.

Inpatient at time of enrollment

Regardless of what program or Managed Care Plan the Member is enrolled in at discharge, the Managed Care Plan the Member is enrolled with on the date of admission shall be responsible for payment of all covered inpatient facility services provided from the date of admission until the date the Member is discharged

Professional services rendered during the course of an inpatient admission are the responsibility of the Managed Care Plan in which the Member is enrolled on the date of service.

Eligibility Verification

Medicaid Programs

The Department of Children and Families (DCF) determines eligibility for Medicaid. Eligibility is determined on a monthly basis. Payment for services rendered is based on eligibility and benefit entitlement. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

Eligibility listing for Medicaid Programs

Providers can verify eligibility for Medicaid Program recipients by calling the Automated Voice Response System (AVRS) at (800) 239-7560 or by visiting the fiscal agent's website at https://mymedicaid-florida.com. When calling to verify a Member's eligibility, Providers will need their own NPI number AND 10-digit Taxonomy number

OR Medicaid Provider ID number. They will also need the Member's 10-digit recipient number OR Social Security number AND Date of Birth OR 8-digit classic card control number.

Providers my also access recipient's eligibility information on the Medicaid Eligibility Verification System (MEVS) via the following:

- Provider Self Services Automated voice response (FaxBack) that generates a report with all the eligibility information for a particular recipient, which is automatically faxed to the provider's fax machine.
- Automated voice response that provides eligibility information using a touch-tone telephone
- X12N 270/271 Health Care Eligibility Benefit Inquiry and Response

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

- Provider Services: (866) 322-4076
- Availity portal: Provider.MolinaHealthcare.com

Possession of a Medicaid ID Card does not mean a recipient is eligible for Medicaid services. A provider should verify a recipient's eligibility each time the recipient receives services. The verification sources can be used to verify a recipient's enrollment in a Managed Care Plan. The name and telephone number of the Managed Care Plan are given along with other eligibility information.

Each Medicaid eligible recipient receives an individual identification card from DCF. The recipient is instructed to retain the card even during periods of ineligibility. If the recipient becomes ineligible for Medicaid and later becomes eligible, the same ID card is used.

The Florida Medicaid Identification card is a gold plastic card with a magnetically encoded stripe. Recipients who are eligible for MediKids have a blue and white plastic card with a magnetically encoded stripe.

The provider must submit a claim to the Managed Care Plan using the recipient's ten-digit Medicaid ID number. This number is not on the Medicaid identification card. The eight-digit number on the front of the Medicaid identification card is the card control number used to access the recipient's file and verify eligibility. It is not the recipient's ten-digit Medicaid identification number that is entered on claims for billing.

The provider may obtain this information by looking up the recipient's eligibility record on MEVS, Faxback, or AVRS using the card control number. The provider should record the recipient's Medicaid ID number obtained from the eligibility verification for billing purposes. The Medicaid ID number will be included on the valid proof of eligibility.

All Members enrolled with Molina receive an identification card from Molina in addition to the Florida Medicaid ID card. Molina sends an identification card for each family Member covered under the plan. Members are reminded in their Member Handbooks to carry both ID cards (Molina ID card and Florida Medicaid card) with them when requesting medical or pharmacy services. It is the Provider's responsibility to ensure Molina Members are eligible for benefits and to verify PCP assignment, prior to rendering services. Unless an emergency condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

Disenrollment

Molina must not restrict the Member's right to disenroll voluntarily in any way. Neither it, nor its subcontractors, providers or vendors shall provide or assist in the completion of a disenrollment request or assist the Agency's enrollment broker in the Disenrollment process.

Members requesting disenrollment from Molina must be referred to the Agency. Providers should inform Molina in writing when a Member has been referred to the Agency's enrollment broker for disenrollment.

Disenrollment for no cause

A mandatory Member subject to open enrollment may submit to the Agency or its enrollment broker a request to disenroll from Molina without cause at the following times:

1. During the 120 days following the enrollee's initial enrollment, or the date the Agency or its enrollment broker sends the enrollee notice of the enrollment, whichever is later;
2. At least every 12 months during a recipient's annual open enrollment period;
3. During the 120 days following the enrollee's re-enrollment if a temporary loss of eligibility causes the enrollee to miss the open enrollment period;
4. When the Agency or its enrollment broker grants the enrollee the right to terminate enrollment without cause (done on a case-by-case basis); and

5. During the 30 days after the enrollee is referred for hospice services in order to enroll in another Managed Care Plan to access the enrollee's choice of hospice provider.

Voluntary enrollees not subject to open enrollment may disenroll without cause at any time.

Disenrollment for good cause

A mandatory Member may request disenrollment from Molina for cause at any time. Such requests shall be submitted to the Agency or its enrollment broker. The following reasons constitute cause for disenrollment from Molina:

1. The enrollee does not live in a region where the Managed Care Plan is authorized to provide services, as indicated in FMMIS.
2. The provider is no longer with the Managed Care Plan.
3. The enrollee is excluded from enrollment.
4. A substantiated marketing or community outreach violation has occurred.
5. The enrollee is prevented from participating in the development of their treatment plan/plan of care.
6. The enrollee has an active relationship with a provider who is not on the Managed Care Plan's panel but is on the panel of another Managed Care Plan. "Active relationship" is defined as having received services from the provider within the six months preceding the disenrollment request.
7. The enrollee is in the wrong Managed Care Plan as determined by the Agency.
8. The Managed Care Plan no longer participates in the region.
9. The state has imposed intermediate sanctions upon the Managed Care Plan, as specified in 42 CFR 438.702(a)(3).
10. The enrollee needs related services to be performed concurrently, but not all related services are available within the Managed Care Plan network, or the enrollee's PCP has determined that receiving the services separately would subject the enrollee to unnecessary risk.
11. The Managed Care Plan does not, because of moral or religious objections, cover the service the enrollee seeks.
12. The enrollee missed open enrollment due to a temporary loss of eligibility.
13. Other reasons per 42 CFR 438.56(d)(2) and s. 409.969(2), F.S., including, but not limited to: poor quality of care; lack of access to services covered under the Contract; inordinate or inappropriate changes of PCPs; service access impairments due to significant changes in the geographic location of services; an unreasonable delay or denial of service; lack of access to providers

experienced in dealing with the enrollee's health care needs; or fraudulent enrollment.

Voluntary enrollees may disenroll from Molina Healthcare at any time.

Involuntary disenrollment

Under very limited conditions and in accordance with Agency guidelines, Members may be involuntarily disenrolled from Molina. With proper written documentation and approval by the Agency, the following are acceptable reasons for which Molina may submit involuntary disenrollment requests to the Agency or its enrollment broker, as specified by the Agency:

1. Fraudulent use of the enrollee identification (ID) card. In such cases the Managed Care Plan shall notify MPI of the event.
2. Falsification of prescriptions by an enrollee. In such cases the Managed Care Plan shall notify MPI of the event.
3. The enrollee's behavior is disruptive, unruly, abusive, or uncooperative to the extent that enrollment in the Managed Care Plan seriously impairs the organization's ability to furnish services to either the enrollee or other enrollees.
    a) This provision does not apply to enrollees with medical or mental health diagnoses if the enrollee's behavior is attributable to the diagnoses.
    b) An involuntary disenrollment request related to enrollee behavior must include documentation that the Managed Care Plan:
        i. Provided the enrollee at least one oral warning and at least one written warning of the full implications of the enrollee's actions;
        ii. Attempted to educate the enrollee regarding rights and responsibilities;
        iii. Offered assistance through care coordination/case management that would enable the enrollee to comply;
        iv. Determined that the enrollee's behavior is not related to the enrollee's medical or mental health condition.

Molina will not request disenrollment of an enrollee due to:

1. Health diagnosis;
2. Adverse changes in an enrollee's health status;
3. Utilization of medical services;
4. Diminished mental capacity;
5. Pre-existing medical condition;

6. Uncooperative or disruptive behavior resulting from the enrollee's special needs (with exceptions);
7. Attempt to exercise rights under the Managed Care Plan's grievance system; or
8. Request of a provider to have an enrollee assigned to a different provider outside of Molina's provider network.

Molina will not submit a disenrollment request to be effective later than 45 days after Molina's receipt of the reason for involuntary disenrollment. The Managed Care Plan shall ensure that involuntary disenrollment documents are maintained in an identifiable enrollee record.

Molina will send written notification to the enrollee that the Managed Care Plan is requesting disenrollment, the reason for the request, and an explanation that the Molina is requesting that the enrollee be disenrolled in the next Contract month, or earlier if necessary. Until the enrollee is disenrolled, Molina will be responsible for the provision of services to that enrollee.

PCP dismissal

A PCP may dismiss a Member from his/her practice based on standard policies established by the PCP. Reasons for dismissal must be documented by the PCP and may include:

- For a Member who continues not to comply with a recommended plan of health care. Such requests must be submitted at least sixty (60) calendar days prior to the requested effective date.
- For a member whose behavior is disruptive, unruly, abusive, or uncooperative to the extent that the behavior seriously impairs the organization's ability to furnish services to either the Member or other Members. This Section does not apply to Members with mental health diagnoses if the Member's behavior is attributable to the mental illness.

Missed appointments

The provider will document and follow up on appointments missed and/or canceled by the Member. Members who miss three consecutive appointments within a six-month period may be considered for disenrollment from a provider's panel. Such a request must be submitted at least 60 calendar days prior to the requested effective date. The provider agrees not to charge a Member for missed appointments.

A Member may only be considered for an involuntary disenrollment after the Member has had at least one verbal warning and at least one written warning of the full implications of his or her failure of actions. The Member must receive written notification in fourth grade reading level from the PCP explaining in detail the reasons for dismissal from the practice. Action related to request for involuntary disenrollment conditions must be clearly documented by providers in the Member's records and submitted to Molina Healthcare. The documentation must include attempts to bring the Member into compliance. A Member's failure to comply with a written corrective action plan must be documented. For any action to be taken, it is mandatory that copies of all supporting documentation from the Member's file are submitted with the request. Molina Healthcare will contact the Member to educate the Member of the consequences of behavior that is disruptive, unruly, abusive, or uncooperative and/or assist the Member in selecting a new PCP. The current PCP must provide emergency care to the Member until the Member is transitioned to a new PCP.

PCP Assignment

Molina will offer each Member a choice of PCPs. After making a choice, each Member will have a single PCP. Molina will assign a PCP to those Members who did not choose a PCP at the time of Molina selection. Molina will take into consideration the Member's last PCP (if the PCP is known and available in Molina's contracted network), closest PCP to the Member's home address, zip code location, keeping Children/Adolescents within the same family together, age (adults versus Children/Adolescents) and gender restrictions. Molina will assign all Members that are reinstated after a temporary loss of eligibility to the PCP who was treating them prior to loss of eligibility, unless the Member specifically requests another PCP, the PCP no longer participates in Molina or is at capacity, or the Member has changed geographic areas.

Molina will allow pregnant Members to choose the Health Plan's obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP. Molina shall assign a pediatrician or other appropriate PCP to all pregnant Members for the care of their newborn babies no later than the beginning of the last trimester of gestation. If Molina was not aware that the Member was pregnant until she presented for delivery, it will assign a pediatrician or a PCP to the newborn baby within one business day after birth. Providers shall advise all Members of the Members' responsibility to notify Molina and their DCF public assistance specialists (case workers) of their pregnancies and the births of their babies.

For members who are pregnant and enrolled in the Specialty plan, the baby does not meet the criteria of the mother's plan and would need to be enrolled in his/her own plan.

PCP Changes

A Member may change the PCP at any time with the change being effective no later than the beginning of the month following the Member's request for the change. If the Member is receiving inpatient hospital services at the time of the request, the change will be effective the first of the month following discharge from the hospital.

6. Benefits and covered services

This section provides an overview of the medical benefits and covered services for Molina Members. Some benefits may have limitations. If there are questions as to whether a service is covered or requires prior authorization. please reference the prior authorization tools located on the Molina website and the Availity portal. You may also please contact Molina. Molina shall provide the services listed below in accordance with the Florida Medicaid Coverage Policy, the Florida Medicaid Coverage and Limitations Handbooks, the Florida Medicaid fee schedules, and the provisions in its contract with the Agency. Molina shall comply with all state and federal laws pertaining to the provision of such services. The following provisions highlight key requirements for certain covered services, including requirements specific to the MMA program.

Covered Services

Behavioral Health services will be managed through Molina for MMA and Specialty members.

Service	Description	Coverage/Limitations	Prior Authorization
Allergy Services	Services to treat conditions such as sneezing or rashes that are not caused by an illness	We cover blood or skin allergy testing and up to 156 doses per year of allergy shots.	Yes –For Specialties other than: Allergists, Allergy & Immunologists, Otolaryngologists, and Pulmonologists
Ambulance Transportation Services	Ambulance services are for when you need emergency care while being transported to the hospital or special	Covered as medically necessary.	No – Emergency Services Yes – for transport between facilities

Service	Description	Coverage/Limitations	Prior Authorization
	support when being transported between facilities		
Ambulatory Surgical Center Services	Surgery and other procedures that are performed in a facility that is not the hospital (outpatient)	Covered as medically necessary.	Some services require Prior Authorization. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.
Anesthesia Services	Services to keep you from feeling pain during surgery or other medical procedures	Covered as medically necessary.	Some services require Prior Authorization. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.
Assistive Care Services	Services provided to adults (ages 18 and older) help with activities of daily living and taking medication	We cover 365/366 days of services per year	Yes. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.
Behavior Analysis (BA)	Structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.	We cover recipients under the age of 21 years requiring medically necessary services.	Yes. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.
Behavioral Health Assessment Services	Services used to detect or diagnose mental illnesses and behavioral health disorders	We cover medically necessary services as listed on the Florida Medicaid Community Behavioral Health Fee Schedule:	No – For specialty SMI members Yes- all others

Service	Description	Coverage/Limitations	Prior Authorization
		- Bio-Psychosocial Evaluation - Brief Behavioral Health Status Examination - In-depth Assessment - Limited Functional Assessment - Psychiatric Evaluation - Psychological Testing - Treatment Plan Development - Treatment Plan Review	
Behavioral Health Overlay Services	Behavioral health overlay services include mental health, substance abuse, and supportive services designed to meet the behavioral health treatment needs of recipients in the care of Medicaid enrolled, certified agencies under contract with the Department of Children and Families, Child Welfare and Community-Based Care organization.	- We cover 365/366 days of services per year for children under 21. - Behavioral health overlay services include the following components: Therapy, Behavior management, Therapeutic support	Yes. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.
Cardiovascular Services	Services that treat the heart and circulatory	We cover the following as prescribed by your doctor:	Some services require Prior Authorization. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.

Service	Description	Coverage/Limitations	Prior Authorization
	(blood vessels) system	- Cardiac testing - Cardiac surgical procedures - Cardiac devices	
Child Health Services Targeted Case Management	Services provided to children (ages 0 - 3) to help them get health care and other services Or Services provided to children (0-20) who use medical foster care services	Your child must be enrolled in the DOH Early Steps program Or Your child must be receiving medical foster care services	No
Chiropractic Services	Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs	twelve (12) additional visits per year for a maximum of thirty-six (36)	No
Clinic Services	Health care services provided in a county health department, federally qualified health center, or a rural health clinic	As medically necessary	No
Dialysis Services	Medical care, tests, and other treatments for the kidneys. This service also includes dialysis supplies, and	We cover the following as prescribed by your treating doctor: - Hemodialysis treatments - Peritoneal dialysis treatments	No

Service	Description	Coverage/Limitations	Prior Authorization
	other supplies that help treat the kidneys		
Durable Medical Equipment and Medical Supplies Services	Medical equipment is used to manage and treat a condition, illness, or injury. Durable medical equipment is used over and over again, and includes things like wheelchairs, braces, crutches, and other items. Medical supplies are items meant for one-time use and then thrown away	Some service and age limits apply.	Yes – for **MMA & Specialty only**. Contact Coastal Care Services at: 855-481-0505 Yes - **for Long-Term Care and Comprehensive** – Contact Molina Healthcare Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.
Early Intervention Services	Services to children ages 0 - 3 who have developmental delays and other conditions	We cover: - One initial evaluation per lifetime, completed by a team - Up to 3 screenings per year - Up to 3 follow-up evaluations per year - Up to 2 training or support sessions per week	No
Emergency Transportation Services	Transportation provided by ambulances or air ambulances (helicopter or airplane) to get you to a hospital	Covered as medically necessary.	No

Service	Description	Coverage/Limitations	Prior Authorization
	because of an emergency		
Evaluation and Management Services	Services for doctor's visits to stay healthy and prevent or treat illness	We cover: - One adult health screening (check-up) per year - Child health check-ups are provided based on age and developmental needs - One visit per month for people living in nursing facilities - Up to two office visits per month for adults to treat illnesses or conditions	No
Family Therapy Services	Services for families to have therapy sessions with a mental health professional	We cover: - Up to 26 hours per year Refer to Expanded Benefits Coverage if additional sessions are required.	Yes. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.
Gastrointestinal Services	Services to treat conditions, illnesses, or diseases of the stomach or digestion system	We cover: - Covered as medically necessary	No
Genitourinary Services	Services to treat conditions, illnesses, or diseases of the genitals or urinary system	We cover: - Covered as medically necessary	No
Group Therapy Services	Services for a group of people to have therapy sessions with a mental health professional	We cover as medically necessary: • Up to 39 hours per year	No

Service	Description	Coverage/Limitations	Prior Authorization
Hearing Services	Hearing tests, treatments and supplies that help diagnose or treat problems with your hearing. This includes hearing aids and repairs	We cover hearing tests and the following as prescribed by your doctor: - Cochlear implants - One new hearing aid per ear, once every 3 years - Repairs	Some services require Prior Authorization. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.
Home Health Services	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness, or injury	We cover: For MMA only and Specialty Plan members - Up to 4 visits per day for pregnant recipients and recipients ages 0-20 - Up to 3 visits per day for all other recipients - Personal Care Services for 21 and older For Long Term Care Members: Refer to Long Term Care Specific Covered Services	Yes – for MMA & Specialty only. Contact Coastal Care Services at: 855-481-0505 Yes, for Long-Term Care and Comprehensive – Contact Molina Healthcare
Hospice Services	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers	Covered as medically necessary - See information on Patient Responsibility for more information	No

Service	Description	Coverage/Limitations	Prior Authorization
Individual Therapy Services	Services for people to have one-to-one therapy sessions with a mental health professional	- Up to 26 hours per year Refer to Expanded Benefits Coverage if additional sessions are required.	Some services require Prior Authorization. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.
Inpatient Hospital Services	Medical care that you get while you are in the hospital. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	We cover the following inpatient hospital services based on age and situation: - Up to 365/366 days for recipients ages 0-20 - Up to 45 days for all other recipients (extra days are covered for emergencies)	Yes – Refer to Molina's provider website or portal for s for elective inpatient admissions. For inpatient emergency admission Molina requires notification of admission within 24 hours and concurrent clinical review for Medical Necessity review and Authorization. Some services require Prior Authorization. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.
Integumentary Services	Services to diagnose or treat skin conditions, illnesses, or diseases	Covered as medically necessary	No
Laboratory Services	Services that test blood, urine, saliva, or other items from the body for conditions, illnesses, or diseases	Covered as medically necessary	Lab Specimens should be sent to Quest or LabCorp Some services require Prior Authorization. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.
Medical Foster Care Services	Services that help children with health problems who live in foster care homes	Must be in the custody of the Department of Children and Families	No
Medication Assisted Treatment Services	Services used to help people who are struggling with drug addiction	Covered as medically necessary	Some services require Prior Authorization. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.
Medication Management Services	Services to help people understand	Covered as medically necessary	No

Service	Description	Coverage/Limitations	Prior Authorization
	and make the best choices for taking medication		
Mental Health Targeted Case Management	Services to help get medical and behavioral health care for people with mental illnesses	Covered as medically necessary	Yes. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.
Neurology Services	Services to diagnose or treat conditions, illnesses or diseases of the brain, spinal cord, or nervous system	Covered as medically necessary	No
Non-Emergency Transportation Services	Transportation to and from all your medical appointments. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles	We cover the following services for recipients who have no transportation: - Out-of-state travel - Transfers between hospitals or facilities - Escorts when medically necessary	No, Members can access transportation through Access2Care: (888) 298-4781 8:00AM – 7:00PM est.
Nursing Facility Services	Medical care or nursing care that you get while in a nursing facility.	• Nursing facility services for enrollees under the age of eighteen (18) years. • For 18 and older: For up to one-hundred twenty (120) days from the date of the most recent nursing facility admission, regardless of payer, when: i. The enrollee is in need	Yes. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.

Service	Description	Coverage/Limitations	Prior Authorization
		of long-term nursing facility services and is not receiving nursing facility services in lieu of inpatient hospital services nor admitted for rehabilitation services; ii. The enrollee has completed all PASRR requirements; iii. The DCF has determined the enrollee is eligible for Institutional Care Program (ICP) Medicaid; and iv. The enrollee is not yet enrolled in the Long-Term Care program. • For all enrollees: as In Lieu of Inpatient Hospital Services with Prior Authorization	
Observation Care	Clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether a member will require further acute	Up to 48 hours of observation services without subsequent inpatient admission.	Yes – For Comprehensive and Specialty Plan Contact American Therapy Administrators (HN1) at: 888-550-8800 for MMA and Comprehensive members

Service	Description	Coverage/Limitations	Prior Authorization
	inpatient treatment in the hospital or if they are able to be discharged		
Occupational Therapy Services	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house	We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap: - One initial evaluation per year - Up to 210 minutes of treatment per week - One initial wheelchair evaluation per 5 years We cover for people of all ages: - Follow-up wheelchair evaluations, one at delivery and one 6-months later	Yes – For Comprehensive and Specialty Plan Contact American Therapy Administrators (HN1) at: 888-550-8800 for MMA and Comprehensive members **Yes – for Long-Term Care – Contact Molina Healthcare**
Oral Surgery Services	Services that provide teeth extractions (removals) and to treat other conditions, illnesses or diseases of the mouth and oral cavity	Covered as medically necessary	Yes. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.
Orthopedic Services	Services to diagnose or treat conditions, illnesses or diseases of the bones or joints	Covered as medically necessary	Some services require Prior Authorization. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.
Outpatient Hospital Services	Medical care that you get while you are in the hospital	Emergency services are covered as medically necessary	Some services require Prior Authorization. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.

Service	Description	Coverage/Limitations	Prior Authorization
	but are not staying overnight. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	- Non-emergency services do not have a limit with Prior Authorization	
Pain Management Services	Treatments for long-lasting pain that does not get better after other services have been provided	Covered as medically necessary. Some service limits may apply.	Some services require Prior Authorization. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.
Physical Therapy Services	Physical therapy includes exercises, stretching and other treatments to help your body get stronger and feel better after an injury, illness or because of a medical condition	We cover children ages 0-20 and for adults under the $1,500 outpatient services cap: - One initial evaluation per year - Up to 210 minutes of treatment per week - One initial wheelchair evaluation per 5 years We cover for people of all ages: - Follow-up wheelchair evaluations, one at delivery and one 6-months later	Yes – For Comprehensive and Specialty Plan Contact American Therapy Administrators (HN1) at: 888-550-8800 for MMA and Comprehensive members Yes- for Long-Term Care – Contact Molina Healthcare
Podiatry Services	Medical care and other treatments for the feet	- Up to 24 office visits per year - Foot and nail care - X-rays and other imaging for the	No

Service	Description	Coverage/Limitations	Prior Authorization
		foot, ankle, and lower leg - Surgery on the foot, ankle, or lower leg	
Prescribed Drug Services	This service is for drugs that are prescribed by a doctor or other health care provider	- Up to a 34-day supply of drugs, per prescription - Refills, as prescribed	Some medications require prior authorization (PA) or have limitations on age, dosage and/or quantities. For a complete list of covered medications please visit Pharmacy Policy (myflorida.com).
Private Duty Nursing Services	Nursing services provided in the home to people ages 0 to 20 who need constant care	- Up to 24 hours per day	Yes
Psychological Testing Services	Tests used to detect or diagnose problems with memory, IQ, or other areas	- 10 hours of psychological testing per year	Some services require Prior Authorization. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.
Psychosocial Rehabilitation Services	Services to assist people re-enter everyday life. They include help with basic activities such as cooking, managing money, and performing household chores	Up to 480 hours per year Refer to Expanded Benefits Coverage if additional sessions are required.	Some services require Prior Authorization. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.
Radiology and Nuclear Medicine Services	Services that include imaging such as x-rays, MRIs, or CAT scans. They also include portable x-rays	Covered as medically necessary	Some services require Prior Authorization. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.
Regional Perinatal Intensive Care Center Services	Services provided to pregnant women and	Covered as medically necessary	No

Service	Description	Coverage/Limitations	Prior Authorization
	newborns in hospitals that have special care centers to handle serious conditions		
Reproductive Services	Services for women who are pregnant or want to become pregnant. They also include family planning services that provide birth control drugs and supplies to help you plan the size of your family	– We cover family planning services. – You can get these services and supplies from any Medicaid provider; they do not have to be a part of our Plan. – You do not need prior approval for these services. – These services are free. – These services are voluntary and confidential, even if you are under 18 years old.	No
Respiratory Services	Services that treat conditions, illnesses or diseases of the lungs or respiratory system	- Respiratory testing - Respiratory surgical procedures - Respiratory device management	No
Respiratory Therapy Services	Services for recipients ages 0-20 to help you breathe better while being treated for a respiratory condition, illness, or disease	- One initial evaluation per year - One therapy re-evaluation per 6 months - Up to 210 minutes of therapy treatments per week (maximum of 60 minutes per day)	Yes. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.
Specialized Therapeutic Services	Services provided to children ages 0-20 with mental	- Assessments - Foster care services - Group home services	Some services require Prior Authorization. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.

Service	Description	Coverage/Limitations	Prior Authorization
	illnesses or substance use disorders		
Speech-Language Pathology Services	Services that include tests and treatments help you talk or swallow better	We cover the following services for children ages 0-20: - Communication devices and services - Up to 210 minutes of treatment per week - One initial evaluation per year We cover the following services for adults: - One communication evaluation per 5 years	Yes – Contact American Therapy Administrators (HN1) at: 888-550-8800 for MMA & Comprehensive members **Long-Term Care –** Contact Molina Healthcare
Statewide Inpatient Psychiatric Program Services	Services for children with severe mental illnesses that need treatment in the hospital	Covered as medically necessary for children ages 0-20	Yes. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.
Therapeutic Behavioral On-Site Services	Services provided by a team to prevent children ages 0-20 with mental illnesses or behavioral health issues from being placed in a hospital or other facility	- Therapy and Behavior Management: maximum combined limit of a total of 36 15-minute units per month. - Therapeutic Support: maximum of 128 quarter-hour units per month (32 hours)	Yes. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.
Transplant Services	Services that include all surgery and pre- and post-surgical care	Covered as medically necessary	Yes. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.

Service	Description	Coverage/Limitations	Prior Authorization
Visual Aid Services	Visual Aids are items such as glasses, contact lenses and prosthetic (fake) eyes	We cover the following services when prescribed by your doctor: - Two pairs of eyeglasses for children ages 0-20 - Contact lenses - Prosthetic eyes	No
Visual Care Services	Services that test and treat conditions, illnesses, and diseases of the eyes	Covered as medically necessary	Some services require Prior Authorization. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.

Covered Specialty Services - Long-Term Care

The table below lists the long-term care services covered by our Plan. Remember, services must be medically necessary for us to pay for them.

If you have any questions about any of the covered long-term care services, please call Case Management or Provider Services.

Service	Description	Prior Authorization
Adult Companion Care	This service helps you fix meals, do laundry and light housekeeping	Yes
Adult Day Health Care	Supervision, social programs, and activities provided at an adult day care center during the day. If you are there during mealtimes, you can eat there.	Yes
Assisted Living	These services are usually provided in an assisted living facility. Services can include housekeeping, help with bathing, dressing, and eating, medication assistance, and social programs.	Yes
Assistive Care Services	These are 24-hour services if you live in an adult family care home or an assisted living facility	Yes
Attendant Nursing Care	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness, or injury	Yes
Behavioral Management	Services for mental health or substance abuse needs	Yes

Caregiver Training	Training and counseling for the people who help take care of you	Yes
Care Coordination/ Case Management	Services that help you get the services and support you need to live safely and independently. This includes having a case manager and making a plan of care that lists all the services you need and receive.	No
Home Accessibility/ Adaptation Services	This service makes changes to your home to help you live and move in your home safely and more easily. It can include changes like installing grab bars in your bathroom or a special toilet seat. It does not include major changes like new carpeting, roof repairs, plumbing systems, etc.	*Yes*
Home Delivered Meals	This service delivers healthy meals to your home	Yes
Homemaker Services	This service helps you with general household activities, like meal preparation and routine home chores	Yes
Hospice	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers.	No
Intermittent and Skilled Nursing	Extra nursing help if you do not need nursing supervision all the time or need it at a regular time	Yes
Medication Administration	Help taking medications if you can't take medication by yourself	Yes
Medical Equipment and Supplies	Medical equipment is used to help manage and treat a condition, illness, or injury. Medical equipment is used repeatedly and includes things like wheelchairs, braces, walkers, and other items. Medical supplies are used to treat and manage conditions, illnesses, and injuries. They include items that are used and then thrown away, like bandages and gloves.	Yes
Medication Management	A review of all the prescription and over-the-counter medications you are taking	Yes
Nursing Facility Services	Nursing facility services include medical supervision, 24-hour nursing care, help with day-to-day activities, physical therapy, occupational therapy, and speech-language pathology	Yes

Nutritional Assessment/Risk Reduction Services	Education and support for you and your family or caregiver about your diet and the foods you need to eat to stay healthy	Yes
Personal Care	These are in-home services to help you with: • Bathing • Dressing • Eating • Personal Hygiene	Yes
Personal Emergency Response Systems (PERS)	An electronic device that you can wear or keep near you that lets you call for emergency help anytime	Yes
Respite Care	This service lets your caregivers take a short break. You can use this service in your home, an Assisted Living Facility, or a Nursing Home.	Yes
Occupational Therapy	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house	Yes
Physical Therapy	Physical therapy includes exercises, stretching, and other treatments to help your body get stronger and feel better after an injury, illness, or because of a medical condition	Yes
Respiratory Therapy	Respiratory therapy includes treatments that help you breathe better	Yes
Speech Therapy	Speech therapy includes tests and treatments that help you talk or swallow	Yes
Structured Family Caregiving	Services provided in your home to help you live at home instead of in a nursing facility	We may offer the choice to use this service instead of nursing facility services.
Transportation	Transportation to and from all your LTC program services. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles.	No

Expanded Benefits – MMA Plan

The table below lists the expanded services covered by our Plan. Please refer to our Prior Authorization (PA) Tool on our website for requirements.

Aging in Place Housing Assistance Grant	H0044	Support for miscellaneous housing expenses to allow for	21	99	Up to $2500 per enrollee per lifetime with prior authorization	Yes

		aging in place and remaining in the community				
Ambulatory Detox Services	S9475	Ambulatory setting substance abuse treatment or detoxification services, per diem	21+	No	Unlimited, with Prior Auth	Yes
Biometric Equipment	A4670	Digital Blood Pressure Monitor	21+		1 Digital blood pressure cuff every three 3 years;(1) weight scale every three (3) years	Yes
	E1639	Weight Scale				
Caregiver Transportation	A0200	Non-medical transportation for a caregiver	18	No Max	Four (4) one-way trips monthly to visit a member who is residing at an ALF	No
Cellular Phone Services	A9270 U1	Non-covered Item or Service	18	No Max	350 minutes; unlimited text messages; 16 GB data	No
Chiropractic	98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions	21	No Max	twelve (12) additional visits per year for a maximum of thirty-six (36)	No
	98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions				
	98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions				
	98943	Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions				
Collaborative Care	99366-99368	Team Conference, with or without patient	6	No Max	Unlimited	No

Diapers for New Moms	A4520	Post live delivery Diapers	10	59	one (1) case per month for up to six (6) months following baby's birth with prior authorization	Yes
Doula Services	S9442-S9446 59400 59409 59510 59514 59610 59612 59618 59620	Antepartum Classes, Post-partum education and Labor Support	10	59	up to eight (8) total classes/education sessions per pregnancy from the following CPT codes (S9442-S9446) and one (1) labor support during delivery per delivery/Pregnancy	No
Hearing Services	V5010-V5011, V5050 V5060 V5090 V5130 V5140 V15160 V5181 V5200 V5221 V5240 92557	Assessment For Hearing Aid Hearing Aid Fitting/Checking Hearing Aid Monaural In Ear Behind Ear Hearing Aid Hearing Aid Dispensing Fee In Ear Binaural Hearing Aid Behind Ear Binaural Hearing Aid Dispensing Fee Binaural Behind Ear Cros Hearing Aid Cros Hearing Aid Dispense Fee Behind Ear Bicros Hearing Aid Hearing Evaluation	21+	No Max	one (1) Hearing Aid and one (1) Hearing Eval per two (2) years	Yes - Please refer to the PA Tool for requirements: molinahealthcare.com/providers/fl/medicaid/home.aspx
Home Delivered Meals - Disaster Preparedness/ Relief	S9977	Meals, per diem	0	No Max	With Prior Authorization, one (1) delivery annually of two (2) meals per day for fourteen (14) days	Yes

					(twenty-eight (28) meals total) – Shelf Stable Meals	
Home Delivered Meals - Post-Facility Discharge (Hospital or Nursing Facility)	S9977	Meals per diem; not otherwise specified	0	No Max	3 meals per day for 30 days	Yes
Home Health Nursing/Aide Services	S9122	Home health aide or certified nurse assistant, providing care in the home; per hour.	21	No Max	Unlimited with Prior Authorization for: home visits by a home health aide or certified nurse assistant (per hour and per visit); nursing care in the home provided by a registered nurse or licensed practical nurse (per hour and per diem); and personal care services (per fifteen (15) minute units and per diem)	Yes
	S9123	Nursing care, in the home; by registered nurse, per hour				
	S9124	Nursing care, in the home; by a licensed practical nurse, per hour				
	T1019	Personal Care, Per 15 Min				
	T1020	Personal Care, Per Diem				
	T1021	Home Health Aide Or Certified Nursing Aide, Per Visit				
	T1030	Registered Nurse Home Care, Per Diem				
	T1031	Licensed Practical Nurse, Home Care, Per Diem				
Medically Tailored and	S9977	Meals, per diem	10	59	High Risk (HR) – 2 per day/8 weeks per	Yes

Culturally appropriate meals					CY/Pregnancy, Non-HR – 2 per day/4 weeks per CY/Pregnancy	
Home-delivered meals-Chronic Conditions	S9977	Meals, per diem	0	99	Chronic Conditions - Up to 2 meals per day/8 weeks per CY	Yes
Individual Therapy Sessions for Caregivers	H2019 HR XU 90846	Psychotherapy services	18	65	As needed with Prior Auth	Yes
Life Skills Development	H2014 U1	Skills training and development; per 15 minutes	12	21	With Prior Authorization, up to 160 hours per calendar year, for children or adolescents with a diagnosed development disability to provide life skills development that help the child or adolescent keep, learn or improve skills and functioning for daily living. These services will be provided in the home or outpatient setting.	Yes
Mobile PERS Program	S5161 XU	Mobile Personal Emergency Response System (PERS) and service	21	99	one (1) Equipment per enrollee and up to twelve (12) Monthly Service fees per year, with prior authorization	Yes
Newborn circumcision	54160	Circumcision Neonate	0 days old	31 days old	one (1) per lifetime	No
Nutritional Counseling	S9452 97802 97803 97804 G0270	Nutrition Class Medical Nutrition Indiv In Med Nutrition Indiv Subseq Medical Nutrition Group Mnt Subs Tx For Change Dx	21	No Max	Limit of five (5) visits per year for: nutrition class, medical nutrition individual initial and subsequent treatment, group medical nutrition, and individual and group medical nutrition therapy after a change in diagnosis, medical condition, or treatment regimen	Yes

	G0271	Group Mnt 2 Or More 30 Mins				
Over the Counter (OTC) medications and supplies	N/a	Various OTC items as listed in OTC catalog, such a Cough, cold and allergy medications, Vitamins and supplements, Ophthalmic/ Otic preparations, Pain relievers, Gastrointestinal products, First aid care, Hygiene products, Insect repellant (deet and non-deet), Oral hygiene products, Skin care, Smoking cessation products, and Antifungals	0	No Max	• $65 per household, per month for non-pregnant members • $70 for pregnant enrollees	No
Adult additional primary care services	99211-99215	Office/ Outpatient Visit Established Patient	21	No Max	Unlimited	No
	99307-99310	Nursing Fac Care Subsequent				
	99395-99397	Prev Visit Established Patient				
	99474	Self-Measured Blood Pressure Monitoring				
Pet Support	A9999XU	Reimbursement for kenneling of their pet	21	No Max	Up to $500 per HCBS Waiver enrollee per Calendar Year	Yes

		during an admission or expenses such as pet food or vet bills				
Physical Therapy	97113	Aquatic Therapy/Exercises	21	99	HCBS Waiver Members Up to two (2) months of Aqua therapy per calendar year, with prior authorization	Yes
Prenatal Services	E0603	Breast Pump Rental	21	No Max	one (1) per year E0604 rental (PA is required), one (1) per two (2) years E0603 rental (no PA required), Fourteen (14) Antepartum visits for low-risk pregnancies and Eighteen (18) Antepartum visits for high-risk pregnancies with no PA required, three (3) visits within ninety (90) days following delivery, and one (1) well-woman visit between ninety (90) days and twelve (12) months following delivery in preparation to transition back to the primary care medical home	Some services require prior auth. Please refer to the PA Tool for requirements: molinahealthcare.com/providers/fl/medicaid/home.aspx
	E0604 (RO)	Breast Pump Rental				
	H1000	Antepartum Management				
	59430	Post-Partum Care				
Service/Therapy Animal Benefit	90899	Service/Therapy Animal Training and/or Maintenance	6	20	With Prior Authorization, up to $5000 total per enrollee per lifetime (may be paid over multiple years to active members). Max twenty (20) stipends per year.	Yes
Behavioral Health - Therapy/ Psychotherapy (Group)	H2010 HQ	Group therapy	21	99	Unlimited	No
	H2019 HQ	Brief Group Medical Therapy				
Behavioral Health - Therapy/	H2010 HE/HF	Individual and Family Therapy	21	99	Unlimited, Prior Authorization required	Yes

Psychotherapy (Individual/Family)	H2019 HR	Brief Individual Psychotherapy			after 104 units (26 hours)	
Occupational therapy for adults	97165	Occupational Therapy Evaluation Low To High Complexity,	21	No Max	• one (1) eval and/or one (1) Re-eval per year • up to seven (7) therapy units per week • two (2) applications of casting or strapping per year • one (1) additional wheelchair eval per five (5) years for total of two (2) per five (5) years	Yes – For Comprehensive and Specialty Plan Contact American Therapy Administrators (HN1) at: 888-550-8800 for MMA and Comprehensive members **Yes – for Long-Term Care – Contact Molina Healthcare**
	97166	Occupational Therapy Evaluation Low To High Complexity				
	97167	Occupational Therapy Evaluation Low To High Complexity				
	97168	Occupational Therapy Re-Evaluation,				
	97530	Occupational Therapy Treatment Visit,				
	29799 HA	Application Of Casting Or Strapping,				
	97542 GO	Wheelchair Evaluation and Fitting by an Occupational Therapist				
Physical Therapy for adults	97161	Physical therapy evaluation or re-evaluation,	21	No Max	one (1) eval and/or one (1) Re-eval per year, up to seven (7) therapy units per week, two (2) applications of casting or strapping per year, one (1) additional wheelchair eval per five (5) years for total of two (2) per five (5) years	Yes – For Comprehensive and Specialty Plan Contact American Therapy Administrators (HN1) at: 888-550-8800 for MMA and Comprehensive members **Yes – for Long-Term Care – Contact Molina Healthcare**
	97162	Physical therapy evaluation or re-evaluation				
	97163	Physical therapy evaluation or re-evaluation				
	97164	Physical therapy evaluation or re-evaluation				

	97110	physical therapy treatment visit				
	29799 HA	application of casting or strapping				
	97542 GP	wheelchair evaluation and fitting by a physical therapist				
Respiratory Therapy	S5180	Home Health Respiratory Therapy Services	21	No Max	With Prior Authorization, one (1) initial evaluation and one (1) re-evaluation per year; one (1) respiratory therapy visit per day	Yes
	G0238	Home Health Respiratory Therapy Services				
Speech Therapy	92521-92524	Speech therapy services	21	No Max	With Prior Authorization: One (1) evaluation and re-evaluation per year; one (1) evaluation of oral and pharyngeal swallowing function per year; up to seven (7) therapy treatment units per week; one (1) augmentative and alternative communication (AAC) initial evaluation and one (1) AAC re-evaluation per year; up to four (4) thirty (30)-minute AAC fitting, adjustment, and training sessions per year	Yes – For Comprehensive and Specialty Plan Contact American Therapy Administrators (HN1) at: 888-550-8800 for MMA and Comprehensive members **Yes – for Long-Term Care – Contact Molina Healthcare**
	92610					
	92507					
	92597					
	92609					
Adult visual aid services	V2500-V2501	Contact lens, PMMA, spherical, per lens	21	No max	six (6) months' supply of contact lenses with prescription, one (1) frame per year, one (1) exam per year	No
	V2511	Contact lens, PMMA, Toric or prism ballast, per lens				

	V2513	Contact lens, gas permeable, Toric, prism ballast, per lens				
	V2520-V2521	Contact lens, gas permeable, extended wear, per lens				
	V2523	Contact lens, hydrophilic, spherical, per lens				
	V2599	Contact lens, hydrophilic, Toric, or prism ballast, per lens				
	V2020	Contact lens, hydrophilic, extended wear, per lens				
	V2025	Contact lens, other type frame				
	99173	Eye Exam				
Waived Copayments	N/A	N/A	21	No Max	All services	No

Expanded Benefits – Specialty Plan

The table below lists the expanded services covered for Specialty Members.

Benefit Category	Procedure Code	Modifier	Procedure Code Description	Min Age	Max Age	Expanded Benefit Coverage ((Unit)	Prior Authorization Required
Acupuncture	97810		Acupuncture, one or more needles, without electrical stimulation, initial 15	21	No Max	For HIV Specialty Plan Members Up to 4 units (15 minutes x 4 = 60 minutes) per	No

Benefit Category	Procedure Code	Modifier	Procedure Code Description	Min Age	Max Age	Expanded Benefit Coverage ((Unit)	Prior Authorization Required
			minutes of personal one-on-one contact with the patient			visit - up to 24 visits / year	
	97811		Each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needles				
	97813		Acupuncture, one or more needles, with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient				
	97814		Each additional 15 minutes of personal one-on-one				

Benefit Category	Procedure Code	Modifier	Procedure Code Description	Min Age	Max Age	Expanded Benefit Coverage ((Unit)	Prior Authorization Required
			contact with patient, with re-insertion of needles				
Assessment Services	H2000	HP, HO	Psychiatric Evaluation	21	no limit	For SMI Specialty Members Unlimited with prior authorization	No
	90791		Psychiatric diagnostic evaluation	21	no limit		No
	90792		Psychiatric diagnostic evaluation with medical services	21	no limit		No
	H2010	HO	Brief Behavioral Health Status Exam	21	no limit		No
	H0031		Limited Functional Assessment, Mental Health	21	no limit		No
	H0001		Limited Functional Assessment, Substance Use	21	no limit		No
	H0031	HO	In-depth Assessment,	21	no limit		No

Benefit Category	Procedure Code	Modifier	Procedure Code Description	Min Age	Max Age	Expanded Benefit Coverage ((Unit)	Prior Authorization Required
			Mental Health				
	H0001	HO	In-depth Assessment, Substance Use	21	no limit		No
	H0001	HN	Biopsychosocial Evaluation, Substance Use	21	no limit		No
	H0031	HN	Biopsychosocial Evaluation, Mental Health	21	no limit		No
	H2019		Psychological Testing	21	no limit		No
	H0031	HA	Mental Health Assessment by No-Physician	21	no limit		No
Behavioral Health Day Services/Day Treatment	H2012		Behavior Health Day Treatment	21	no limit	For SMI Specialty Members Unlimited with prior authorization	Yes
Behavioral Health Screening Services	T1023	HE/HF	Behavioral Health Screening Services	21	no limit	For SMI Specialty Members Unlimited	No
Behavioral Health Medical Services (Verbal Interaction)	H0046		Behavioral Health Medical Services (Verbal Interaction), Mental Health	21	no limit	For SMI Specialty Members Unlimited	No

Benefit Category	Procedure Code	Modifier	Procedure Code Description	Min Age	Max Age	Expanded Benefit Coverage ((Unit)	Prior Authorization Required
	H0047		Behavioral Health Medical Services (Verbal Interaction), Substance Abuse	21	no limit		No
Behavioral Health Medical Services (Medication Management)	T1015	HE/HF	Medication Management	21	no limit	For SMI Specialty Members Unlimited	No
Behavioral Health Medical Services (Drug Screening)	H0048		Behavioral Health Medical Services (Alcohol and Other Drug Screening Specimen Collection)	21	no limit	For SMI Specialty Members Unlimited	No
Collaborative Care	99366		Medical Team Conference, Direct Contact with Patient and/or Family	21	no limit	For SMI Specialty Members Unlimited	No
	99367		Medical Team Conference, without Direct Contact with Patient and/or Family				

Benefit Category	Procedure Code	Modifier	Procedure Code Description	Min Age	Max Age	Expanded Benefit Coverage ((Unit)	Prior Authorization Required
	99368		Medical Team Conference, without Direct Contact with Patient and/or Family				
Medication Assisted Treatment	H0020		Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	21	no limit	For SMI Specialty Members Unlimited with prior authorization	No
Psychosocial Rehabilitation	H2017		Psychosocial rehabilitation services	21	no limit	For SMI Specialty Members Unlimited with prior authorization and meeting medical necessity criteria	Yes
Substance Abuse Treatment or Detoxification Services (Outpatient)	S9475		Ambulatory setting substance abuse treatment or detoxification services, per diem	21	no limit	For SMI Specialty Members Unlimited with prior authorization	Yes
Therapy – Massage	97124 97112			21	99		Yes

Benefit Category	Procedure Code	Modifier	Procedure Code Description	Min Age	Max Age	Expanded Benefit Coverage ((Unit)	Prior Authorization Required
	97010 97140		Massage Therapy Services			For SMI Specialty Members Unlimited with prior authorization	
Mental Health Targeted Case Management	T1017	HK	Targeted Case Management	21	no limit	For SMI Specialty Members Unlimited with prior authorization and meeting medical necessity criteria	Yes

Expanded Benefits – Pathways to Prosperity

The table below lists the Pathways to Prosperity expanded services.

Service	Description	Coverage / Limitations	Prior Authorization
Childcare Assistance	Support for pregnant members, after giving birth, upon new employment to begin working	Up to $1500 for two months, once per lifetime	Yes
Criminal Expungement Support	Criminal Expungement Support	Up to $75 per lifetime per enrollee for criminal expungement fee(s)	Yes
Food Assistance	Emergency Food support	$250 once per lifetime, per household, with authorization, for emergency food support	Yes
Housing Assistance	Provides assistance to establish or maintain housing stability	Up to $1500 per member per lifetime, with prior authorization	Yes

Service	Description	Coverage / Limitations	Prior Authorization
GED preparation course reimbursement	GED preparation course reimbursement	Up to $140 for online prep classes once per lifetime per enrollee	Yes
Non-Medical Transportation	Transportation for Plan defined covered trip reasons, such as job interviews, volunteering, support groups, etc.	Up to 10 one-way trips for non-medical purposes, per month, per enrollee	Yes
Specialty Plan Housing Assistance	For Specialty Plan Members Provides assistance to establish or maintain housing stability	Up to $2500 per member per lifetime, with prior authorization	Yes

In Lieu of Services – MMA and Specialty Plan

Molina will provide any of the following in lieu of services to MMA and Specialty Members when it is determined to be medically appropriate and in accordance with the requirements for the provision of in lieu of services contained in this contract, after obtaining approval from the Agency.

**Please Note: Refer to Molina's provider website or portal for specific codes that require authorization.*

Service	Procedure Code	In Lieu of	Description	Coverage/Limitations	PA Required
Addictions Receiving Facility Services	Refer to Medicaid Fee Schedule	Services used to help people who ae struggling with drug or alcohol addiction	As medically necessary and recommended by us	Some services require Prior Authorization. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.	Yes

Ambulatory Detoxification Services	S9475	Inpatient Detoxification Hospital Care	Services provided to people who are withdrawing from drugs or alcohol outside the hospital	As medically necessary and recommended by us	Yes
Community-Based Wrap-Around Services	H2022	Therapeutic Group Care Services or Statewide Inpatient Psychiatric Program Services	Services provided by a mental health team to children who are at risk of going into a mental health treatment facility	As medically necessary and recommended by us	Yes
Crisis Stabilization Unit Services	S9485	Inpatient Psychiatric Hospital	Emergency mental health services that are performed in a facility that is not a regular hospital	As medically necessary and recommended by us	No
Drop-In Center Services	S5102 HE	Clubhouse Services	Services provided in a center that helps homeless people get treatment or housing	As medically necessary and recommended by us	Yes
Family Training and Counseling for Child Development	T1027	Therapeutic Behavioral On-Site Services	Services to support a family during their child's mental health treatment	As medically necessary and recommended by us	Yes
Housing Assistance	H0043 H2015 HK	1 unit = 15 min limited to 30 days 344 units per month or 48 units per day	Services to support housing assistance	As medically necessary and recommended by us	Yes
Infant Mental Health Pre and Post	T1023 HA	Psychological Testing	Testing services by a mental health professional	As medically necessary and recommended by us	No

Testing Services			with special training in infants and young children		
Inpatient Detoxification or Addictions Receiving Facility Services licensed under s. 397, F.S.	N/A	Inpatient Detoxification Hospital Care	Facilities for individuals in need of medical assistance to withdraw from drug and alcohol abuse or dependence, detoxification, and addiction	As medically necessary and recommended by us	Notification of Admission required for Medical Necessity Review.
Behavioral Health Intensive Outpatient Program (IOP)	S9480	Inpatient Hospital Services	Behavioral Health services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education	May be billed on a daily basis, up to four days per week for nine weeks	Yes
Mental Health Partial Hospitalization Program Services	H0035	Inpatient Psychiatric Hospital	Treatment provided for more than 3 hours per day, several days per week, for people who are recovering from mental illness	As medically necessary and recommended by us	Yes

Mobile Crisis Assessment and Intervention Services	H2011 HO	Emergency Behavioral Health Care	A team of health care professionals who provide emergency mental health services, usually in people's homes	As medically necessary and recommended by us	No
Multisystemic Therapy Services			An intensive service focused on the family for children at risk of residential mental health treatment	As medically necessary and recommended by us	Yes
Nursing Facility Services	Refer to Medicaid Fee Schedule	Inpatient Hospital Services	Nursing facility services in lieu of inpatient hospital services when the enrollee does not require long-term nursing facility care and meets the requirements of PASRR	As medically necessary and recommended by us	No
Partial Hospitalization Services	0912	Inpatient Psychiatric Hospital	Services for people leaving a hospital for mental health treatment	As medically necessary and recommended by us	Yes
Psychiatric Specialty Hospital Services	Refer to Medicaid Fee Schedule		Emergency mental health services that are performed in a facility that is not a regular hospital	As medically necessary and recommended by us	No
Self-Help/Peer Services	H0038	Targeted Case Management	Services to help people who are in recovery from an addiction or mental illness	As medically necessary and recommended by us	Yes

Substance Abuse Intensive Outpatient Program Services	H0015/0906	Inpatient Detoxification Hospital Care	Treatment provided for more than 3 hours per day, several days per week, for people who are recovering from substance use disorders	As medically necessary and recommended by us	Yes
Substance Abuse Short-term Residential Treatment Services	H0018	Inpatient Detoxification Hospital Care	Treatment for people who are recovering from substance use disorders	As medically necessary and recommended by us	Yes

Doula services

Doula Services can really depend on the type of Doula the member needs. A ***Birth Doula*** takes care of the laboring mother and provides the necessary physical and emotional support that helps the mother to overcome the discomfort of childbirth. A ***Postpartum Doula*** assists in alleviating the stresses that comes with a newborn baby.

Molina covers Doula Services as an Expanded Benefit for Managed Medical Assistance (MMA)Comprehensive (MMA/LTC), and Specialty Plan members.

Please review the Doula Benefits Grid and Procedure Codes at MolinaHealthcare.com/Providers/FL/Medicaid/Home under Communications > Resources and Training > Billing Guidelines.

Please Note: A Doula ***does not*** perform clinical or medical tasks, such as: examining the mother or baby, or taking temperatures, blood pressure checks or any other type of postpartum clinical care. A doula cannot diagnose or treat in any modality.

Doula Services do not require Prior Authorization. Providers billing for Doula Services should bill according to their Molina contract.

Well Child Visits (formerly CHCUP)

Well Child visits are available to every Medicaid-eligible child under the age of 21. It includes a comprehensive health and developmental history (including assessment of past medical history, developmental history and behavioral health status); comprehensive unclothed physical examination; developmental assessment; nutritional assessment; appropriate immunizations according to the appropriate Recommended Childhood Immunization Schedule for the United States; laboratory testing (including blood lead testing); health education (including anticipatory guidance); dental screening (including a direct referral to a dentist for enrollees beginning at age three or earlier as indicated); vision screening, including objective testing as required; hearing screening, including objective testing as required; diagnosis and treatment; and referral and follow-up as appropriate. A Well Child visit is a comprehensive, preventive health screening service. Well Child visits are performed according to a periodicity schedule that ensures that children have a health screening on a routine basis. In addition, a child may receive a Well Child visit whenever it is medically necessary or requested by the child or the child's parent or caregiver. If a child is diagnosed as having a medical problem, the child is treated for that problem through the applicable Medicaid program, such as physician, dental and therapy services.

To provide Well Child visits, a provider must be enrolled in Medicaid as a provider with a Category of Service (code 55) for Well Child Visit.

As licensed health care professionals you are aware that performing a blood test is a federal requirement at specific intervals during the Well Child visit. This note is to remind you how important it is to document the blood tests you are performing in compliance with this federal mandate. Failure to provide documentation can lead to a federal audit and the requirement to repay Medicaid for fees received.

The Well Child schedule listed below is based on the American Academy of Pediatrics "Recommendations for Preventive Pediatric Health Care" and Florida Medicaid's recommendation to include the seven- and nine-year-old recipients.

Nothing in this Provider Manual waives the EPSDT requirements of 42 U.S.C. § 1396d(r)(5). As such, in accordance with § 1396d(r) and all binding federal precedents interpreting it, Molina must, for Medicaid eligible children under the age of 21, pay for any "other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under

the State plan." (42 U.S.C. 1396d(r)(5)) Molina evaluate the medical necessity of the services and will not place any time caps (e.g., hourly limits, daily limits, or annual limits) or expenditure caps on services for children under the age of 21.

The Well Child Visit schedule is:

- Birth;
- 3-5 days for newborns discharged in less than 48 hours after delivery;
- By 1 month;
- 2 months;
- 4 months;
- 6 months;
- 9 months;
- 12 months;
- 15 months;
- 18 months;
- 24 months;
- 30 months;
- Once every year for ages 3-20.

The child may enter the periodicity schedule at any time. For example, if a child has an initial screening at age four, then the next periodic screening is performed at age five.

* Florida Medicaid recommends check-ups at seven and nine years of age for those children at risk.

The federal guidelines outlined below specify the minimum requirements included in each Well Child Care (WCC) exam for each of the following age groups; The Well Child Care (WCC) exam 0-18 months is scheduled on a monthly basis, once per year for 2-6 years, and at 7-20 years old. During the Well Child visit, providers are required to deliver the following:

Well Child Domain	Infants (0-18) months	Children (2-6) years	Adolescents (7-20) years
Physical Exam and Health History	• History • Height • Weight • Physical exam (all of these)	• History • Height • Weight • Physical exam (all of these)	• History • Height • Weight • Physical exam (all of these)
Development and Behavior Assessment	• Gross motor • Fine motor • Social/emotional • Nutritional (any one of these)	• Gross motor • Fine motor • Communication • Self-help skills • Cognitive skills	• Social/emotional • Regular physical activity • Nutritional (any one of these)

Well Child Domain	Infants (0-18) months	Children (2-6) years	Adolescents (7-20) years
		• Social/emotional • Regular physical activity • Nutritional (any one of these)	
Mental Health Assessment	Mental health (must be addressed)	Mental health (must be addressed)	• Mental health • Substance abuse (either one of these)
Health Education/ Anticipatory Guidance	• Injury prevention • Passive smoking (either one of these)	• Injury prevention • Passive smoking (either one of these)	• Injury prevention • STD prevention • Smoking/tobacco (any one of these)

Since 2003, Health and Recovery Services Administration (HRSA) has used Health Employer Data Information Set (HEDIS) Well-Child and Well-Adolescent measures to assess the health plans' rates for the number of children with qualifying Early Periodic Screening Diagnosis and Treatment Program EPSDT exams.

Providers must conduct these regular exams to meet the AHCA-targeted state standard. When conducting a Well Child exam, please complete AHCA's Well Child Visit Tracking Form, ensure that the completed form is incorporated into the Member's medical record.

One of our goals at Molina is to improve children's health, as measured by our Well Child rates. Your help with this effort is essential. If you have questions or suggestions related to Well Child Care regulations, please call our Health Education line at (855) 322-4076.

Vaccines for Children

The Centers for Disease Control and Prevention (CDC), which provides Vaccines for Children (VFC) funding, has developed strict accountability requirements from the state, local health jurisdictions, and individual providers. Molina Providers should be enrolled in the VFC program through their local health department.

State supplied vaccines are provided at no cost to enrolled providers through the local health department. Florida is a "universal vaccine distribution" state. This means no fees can be charged to patients for the vaccines themselves and no child should be denied state supplied vaccines for inability to pay an administration fee or office visit.

Molina follows AHCA billing guidelines for reimbursing a provider's administration costs. We reimburse per Florida's fee schedule. Providers must bill state-supplied vaccines with the appropriate procedure codes.

Participation in Vaccine for Children Program (VFC)

Providers must enroll in the VFC program to receive free vaccines for 0–18-year-olds through the VFC program. Information regarding the Vaccine for Children (VFC) Program is available by calling the State of Florida Department of Health, Bureau of Immunization, at 800-4-VFC-KID or (800) 483-2543.

Immunizations

Immunization services provide vaccines to induce a state of being immune to or being protected from a disease. Medicaid reimburses these services for recipients from birth through 20 years of age. Molina will reimburse simultaneous administration of all vaccines for which an enrollee under the age of 21 years is eligible at the time of each visit.

Molina Healthcare will follow only contraindications established by the Advisory Committee on Immunization Practices (ACIP), unless:

- In making a medical judgment in accordance with accepted medical practices, such compliance is deemed medically inappropriate; or
- The particular requirement is not in compliance with Florida law, including Florida law relating to religious or other exemptions.

Molina participating providers must have a sufficient supply of vaccines. Providers that are directly enrolled in the VFC program must maintain adequate vaccine supplies.

Eligible recipients

Medicaid eligible recipients from birth through 18 years of age are eligible to receive free vaccines through the federal Vaccine for Children (VFC) Program. The provider is reimbursed only for the administration of the vaccine. The vaccine is free to the provider through the Vaccine for Children (VFC) program, Department of Health.

Title XXI MediKids enrollees do not qualify for the VFC program. Providers must bill Medicaid fee-for- service directly for immunizations provided to Title XXI MediKids participants. Medicaid eligible recipients 19 through 20 years of age may receive

vaccines through their health care provider. These vaccines are not free to the provider and are reimbursed by Molina Healthcare. Reimbursement includes the administration fee and the cost of the vaccine.

Upon request by DCF and receipt of the enrollee's written permission, PCPs are encouraged to provide immunization information about enrollees requesting temporary cash assistance from DCF. This information is necessary in order to document that the enrollee has met the immunization requirements for enrollees receiving temporary cash assistance.

Vaccines for recipients birth through 18 years

For eligible recipients from birth through 18 years of age, vaccines and combination vaccines providing protection against the following diseases are available free to the VFC-enrolled provider through the VFC program:

- Diphtheria, Tetanus and Pertussis (DTaP)
- Hemophilus influenzae Type b (HIB)
- Hepatitis B (pediatric and adult)
- Meningococcal Conjugate (MCV4)
- Pneumococcal (PCV 7)
- Polio (IPV)
- Measles, Mumps, and Rubella (MMR)
- Tetanus and Diphtheria (Td) (Adult)
- Influenza
- Varicella
- Human Papillomavirus (HPV)
- Rotavirus

The following vaccines are available by request or for high-risk areas only through the VFC program:

- Hepatitis A
- Diphtheria and Tetanus (DT) (Pediatric)
- Pneumococcal Polysaccharide (PPV)
- Meningococcal Polysaccharide (MPSV4)

Vaccines for recipients 19 through 20 years

For eligible recipients ages 19 through 20 years, vaccines and combination vaccines providing protection against the following diseases are reimbursable:

- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Influenza
- Measles, Mumps, and Rubella (MMR)
- Meningococcal Conjugate (MCV 4)
- Meningococcal Polysaccharide (MPSV4)
- Pneumococcal Polysaccharide (PPV)
- Tetanus and Diphtheria (Td)
- Varicella

Vaccines for recipients (21) years and older

Medicaid does not cover immunization services for recipients who are 21 years of age and older. However, Molina covers the following:

- Influenza, once per year
- Pneumococcal, once per lifetime (subject to prior authorization)
- Herpes Zoster (Shingles), once per lifetime (subject to prior authorization)

Benefit must be accessed at a participating network Pharmacy.

Vaccines excluded from VFC Program

Medicaid may reimburse the cost of the vaccine and an administration fee for all recipients 0-18 years of age who receive vaccines not covered by the VFC program.

Administration fee reimbursement

Medicaid reimburses an administration fee to physicians, ARNPs and PAs providing free vaccines through the VFC Program to Medicaid eligible recipients from birth through (18) years of age.

Non-Preferred drug exception request process

The Provider may request a prior authorization for clinically appropriate drugs that are not covered under the Member's Medicaid Plan. Using the FDA label, community standards, and high levels of published clinical evidence, clinical criteria are applied to requests for medications requiring prior authorization.

- For a Standard Exception Request, the Member and/or Member's Representative and the prescribing Provider will be notified of Molina's decision within 24 hours of receiving the complete request.
- If the initial request is denied, a notice of denial will be sent in writing to the Member and prescriber within 24 hours of receiving the complete request.
- Members will also have the right to appeal a denial decision, per any requirements set forth by AHCA.
- Molina will allow a 72-hour emergency supply of prescribed medication for dispensing at any time that a prior authorization is not available. Network dispensing pharmacists will use their professional judgment regarding whether or not there is an immediate need every time the 72-hour option is utilized. This procedure will not be allowed for routine and continuous overrides.

Specialty pharmaceuticals/injectables and infusion services

Many self-administered and office-administered injectable products require prior authorization. In some cases, they will be made available through a vendor designated by Molina. More information about our prior authorization process, including a link to the Prior Authorization Request Form, is available in the Health Care Services section of this Provider Manual. Physician administered drugs require the appropriate 11-digit NDC except for vaccinations or other drugs as specified by CMS.

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

For Home Infusion services information, please contact Coastal Care Services at: (855) 481-0505.

Florida SHOTS

Molina Healthcare is enrolled as a data partner with Florida SHOTS (State Health Online Tracking System). All immunization data is submitted using the process and format specified by AHCA.

Vaccine reimbursement

Medicaid reimbursement for providing vaccinations to Medicaid-eligible recipients 19-20 years of age includes the cost of the vaccine and an administration fee.

The provider must bill with the appropriate HCPCS procedure code assigned to the vaccine and a modifier HA when appropriate.

Well child visits

A Well Child screening is reimbursable in addition to reimbursement for immunizations.

Evaluation and management services

Evaluation and management (E&M) services are reimbursable in addition to the administration fee for vaccines, provided the visit is for a separate and identifiable service and the services are documented in the medical record.

Immunization schedule

Providers should use the current Recommended Childhood Immunization Schedule that is developed and endorsed by the Advisory Committee on Immunization Practices, the Committee on Infectious Diseases of the American Academy of Pediatrics, and Infectious Diseases of the American Academy of Family Physicians. The most recent schedule is available on the Centers for Disease Control website at www.cdc.gov.

Procedure codes and fees

See the Physician Services Fee Schedule for the procedure codes and fees. The fee schedules are available on the Medicaid fiscal agent website at http://ahca.myflorida.com/medicaid/review/Promulgated.shtml.

Urgent care services

Urgent care can provide quick after-hours treatment and is appropriate for infections, fever, and symptoms of cold or flu.

Urgent care services are covered by Molina without a referral.

Urgent care services are covered and do not require prior authorization when accessing participating facilities.

Access to behavioral health services

Members needing access to Behavioral Services are available through PCP referral for services or can self-refer by calling Molina's Behavioral Health department at (855) 322-4076. Molina's Nurse Advice Line is also available 24 hours a day, seven days a week for mental health or substance abuse needs. The services Members receive will be confidential. Additional detail regarding Covered Services and any limitations can

be obtained in the benefit information linked above, or by contacting Molina. If inpatient services are needed, prior authorization must be obtained, unless the admission is due to an emergency situation, and inpatient Member cost share will apply.

Emergency mental health or substance use disorder services

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

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

Out-of-area emergencies

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

- Go to the nearest emergency room.
- Call the number on ID card.
- Call Member's PCP and follow-up within 24 to 48 hours.

For out-of-area Emergency Services, out-of-network Providers are directed to call the Molina contact number on the back of the Member's ID card for additional benefit information and may be asked to transfer Members to an in-network facility when the Member is stable.

Transportation

Emergency transportation

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

Non-emergency medical transportation

For Members who have non-emergency medical transportation as a Covered Service, Molina covers transportation through Access2Care Transportation to medical facilities when the Member's medical and physical condition does not allow them to take regular means of public or private transportation (car, bus, etc.). This requires a written prescription from the Member's doctor. Examples of non-emergency medical transportation include, but are not limited to, litter vans and wheelchair accessible vans.

Members must have Prior Authorization from Molina for ground and air ambulance services before the services are given. Prior Authorization not required for vans, taxis, etc. To make a reservation for a transportation service, contact Access2Care's reservation line for Molina Members at: (888) 298-4781.

If Member needs further assistance, they can also call (866) 472-4585 and a Member Services representative will assist them with this request.

Preventive care

Preventive care guidelines are on the Molina website. Please use the link below to access the most current guidelines.

https://www.MolinaHealthcare.com/providers/fl/medicaid/resource/FL_PHGs.aspx

Providers can help by conducting these regular exams in order to meet the targeted state and federal standards. If you have questions or suggestions related to well childcare, please call our Health Education line at (855) 322-4076.

Prenatal care

Molina providers must include the following in all prenatal care:

- A pregnancy test and a nursing assessment with referrals to a physician, PA or ARNP for comprehensive evaluation;
- Referral to care coordination/case management according to the needs of the member;
- Any necessary referrals and follow-up;
- Schedule return prenatal visits at least every four weeks until week 32, every two weeks until week 36, and every week thereafter until delivery, unless the member's condition requires more frequent visits;

- Contact those members who fail to keep their prenatal appointments as soon as possible, and arrange for their continued prenatal care;
- Assist members in making delivery arrangements, if necessary;
- Refer pregnant members to appropriate maternity and family services, including notifying medical service payers of member status for further eligibility determination for the member and unborn infant; and
- Screening of all pregnant members for tobacco use and make certain that the providers make available to pregnant members smoking cessation counseling and appropriate treatment as needed.

Stage of Pregnancy	How often to see the doctor
1 month – 6 months	1 visit a month
7 months – 8 months	2 visits a month
9 months	1 visit a week

Nutritional Assessment/Counseling

Providers must provide nutritional assessment and counseling to all pregnant members and ensure the following:

- The provision of safe and adequate nutrition for infants by promoting breast-feeding and the use of breast milk substitutes;
- Offer a mid-level nutrition assessment;
- Provide individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse or physician; and
- Documentation of the nutrition care plan in the medical record by the person providing counseling.

Obstetrical Delivery

Molina uses generally accepted and approved protocols for both low-risk and high-risk deliveries, including Healthy Start and prenatal screening. For high-risk pregnancies, OB care during labor and delivery must include preparation for symptomatic evaluation and member progression through the final stages of labor and postpartum care.

Preterm delivery risk assessments must be documented in the member's medical record by week 28.

Newborn Care

Molina providers must supply the highest level of care for newborns beginning immediately after birth. Such level of care must include, but not be limited to:

- Instilling of prophylactic eye medications into each eye of the newborn;
- When the mother is Rh negative, securing a cord blood sample for type Rh determination and direct Coombs test;
- Weighing and measuring of the newborn;
- Inspecting the newborn for abnormalities and/or complications;
- Administering one half (.5) milligram of vitamin K;
- APGAR scoring;
- Any other necessary and immediate need for referral in consultation from a specialty physician, such as the Healthy Start (postnatal) infant screen; and
- Laboratory screenings to test for metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect, in accordance with s. 383.14, F.S.

These required laboratory tests shall be processed through the State Public Health Laboratory. Molina will reimburse for these screenings at the established Medicaid rate or specified contracted rate.

Postpartum Care

For postpartum members, Molina providers must:

- Provide a postpartum examination for the member within six weeks after delivery;
- Ensure that its providers supply voluntary family planning, including a discussion of all methods of contraception, as appropriate; and
- Ensure that continuing care of the newborn is provided through the Well Child Care program component and documented in the child's medical record.

Pregnancy Health Management Program

We care about the health of our pregnant members and their babies. Molina's pregnancy program will make sure the member and baby get the needed care during the pregnancy. You can speak with trained Nurses and Care Managers. They can give your office/member the support needed and answer questions you may have. You will be mailed a workbook, and other resources are available to the member. The member will also learn ways to stay healthy after childbirth. Special care is given to those who have a high-risk pregnancy. It is the member's choice to be in the program. They can choose to be removed from the program at any time. Molina is requesting your office to complete the pregnancy notification form (refer to MolinaHealthcare.com for form)

and return it to us as soon as pregnancy is confirmed. Although pregnancy itself is not considered a disease state, a significant percentage of pregnant females on Medicaid are found to be at moderate to high-risk for a disease condition for the mother, the baby or both. The Pregnancy Rewards℠ pregnancy management program strives to reduce hospitalizations and improve birth outcome through early identification, trimester specific assessment and interventions appropriate to the potential risks and needs identified. The Pregnancy Rewards℠ does not replace or interfere with the member's physician assessment and care. The program supports and assists physicians in the delivery of care to members.

Pregnancy Rewards℠ Program Activities

Pregnancy Rewards℠ Pregnancy Health management Program encompasses clinical case management, member outreach and member and provider communication and education. The Prenatal Case Management staff works closely with the provider community in identification, assessment, and implementation of appropriate intervention(s) for every member participating in the program. The program activities include early identification of pregnant members, early screening for potential risk factors, provision of telephonic and written trimester appropriate education to all pregnant members and families, referral of high-risk members to prenatal case management, and provision of assessment information to physicians.

Additional Pregnancy Rewards℠ Program Benefits:

- Prenatal and postpartum care manager follow-up with the patient to ensure that physician and discharge instructions are followed.
- Risk Assessment – An initial health assessment is performed telephonically or via a mailed prenatal screening survey to identify risk factors. Members are stratified to the appropriate level of care, 3 through 4:
    - Level 1 = Normal pregnancy with no identified risks
    - Level 2 = High risk pregnancy with risk factors including but not limited to; < age 18 or > 35, Parity > 5, multi-fetal gestation, inter-pregnancy interval of less than 4 to 6 months, BMI > 30, depression, hyperemesis, thyroid disorder, anemia.
    - Level 3 = High risk pregnancy with risk factors including but not limited to; Alcohol, tobacco or other substance use, past history of an eating disorder, asthma, poor nutrition per initial screening, incompetent cervix, placenta previa, IUGR, pre-eclampsia, hypertension, DVT
    - Level 4 = High risk pregnancy with risk factors including but not limited to; heart disease, lupus or scleroderma, diabetes, epilepsy, active cancer, ESRD, HIV/AIDS, sickle cell, active psychoses, domestic violence.

Participants identified with a nutritional risk will undergo a comprehensive nutrition assessment and a meal plan developed by a Registered Dietitian.

- Prenatal Case Management – Members assessed at level of care 3 – 4 are contacted via telephone for further intervention and education. A care plan is developed and shared with the physician to ensure that all educational and care needs are met. Prenatal case management registered nurses, in conjunction with the treating physician, coordinate health care services, including facilitation of specialty care referrals, coordination of home health care and DME service, and referral to support groups or community social services. The case management database generates reminders for callbacks for specific assessments, prenatal visits, postpartum visits, and well-baby checkups.
- Pregnancy newsletters – Educational newsletters are mailed to members each trimester throughout the pregnancy, including the postpartum period.
- Smoking Cessation – For information about the Molina Smoking Cessation Program or to enroll members, please contact our Disease Management Unit.
- Member Outreach – Pregnancy Rewards℠ Program is promoted to members through various means including, program brochures in new member Welcome Packets, other member mailings, Member newsletters, Provider newsletters, posters and brochures placed in practitioner's offices and marketing materials and collaboration with national and local community-based entities.

Nurse Advice Line

Members may anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, seven days a week, to assess symptoms and help make good health care decisions.

HEALTHLINE 24-Hour Nurse Advice Line
English Phone: (888) 275-8750 Spanish Phone: (866) 648-3537
TTY: (866) 735-2929 or 711 (English) (866) 833-4703 (Spanish)

Molina is committed to helping our Members:

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

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

Health Management Programs

Molina offers programs to help our Members and their families manage various health conditions. For additional information, please refer to the Healthcare Services section of this Provider Manual.

Treatment Adherence

SMI members have medication and treatment adherence programs available to help ensure that they continue in care and obtain maximum benefit from their care.

Through interdisciplinary meetings and treatment planning, we work with our providers to establish and monitor treatment plans targeted and tailored to each member. Through our health guides, peer support specialist and care managers we reach out to members, provide them with the support they need to address barriers influencing their ability to obtain care and aid in transitions of care that can be difficult to navigate. At each step we rely on the collaboration with our network providers to develop treatment adherence strategies that work for our members. Specialty providers, such as Community Mental Health Centers (CMHC), should incorporate both the member's mental health and medical needs into the treatment plan. Community Mental Health Centers have a responsibility to coordinate care with PCPs to ensure members are addressing their primary health needs. Staff at CMHCs can coordinate with Molina's care management team to identify assigned PCPs, access clinical information from Molina's Health Risk Assessment, and access a member's care plan to guide in the treatment of members.

Mental Health and Substance Abuse Assessments

Molina recognizes there are additional tools for assessing substance abuse and mental health and will support the use of other peer-reviewed and validated instruments.

Molina's plan preference is for providers to use the following assessments:

- CAGE-AID for substance abuse
- AUDIT (Alcohol Use Disorders Identification Test)

- DAST-10 (Drug Abuse Screen Test)
- PHQ 9 for depression
- Mental Health Screening Form III
- SBIRT screenings

Continuity of Care for SMI Members

Members in active treatment will continue to receive care from their current provider for the first 60 calendar days with our plan. After the 60 days pass, Molina will work closely with the member and the non-par provider to determine continuation of care by the non-par provider. Molina will only authorize treatment in special cases. Molina's Member Services department will assist members in locating a participating provider after the Continuity of Care period if requested.

Florida's Healthy Start Infant (Postnatal) Risk Screening Instrument

Florida hospitals electronically file the Healthy Start (Postnatal) Risk Screening Instrument Certificate of Live Birth with the CHD in the county of birth within five business days of the birth.

For birthing facilities not participating in the Department of Health electronic birth registration system, required birth information must be filed with the CHD within five business days of the birth. The provider must keep a copy of the completed Healthy Start (Postnatal) Risk Screening Instrument in the member's medical record and mail a copy to the member.

Ineligible members

Pregnant members or infants who do not score high enough to be eligible for Healthy Start case management may be referred for services, regardless of their score on the Healthy Start risk screen, in the following ways:

- If the referral is to be made at the same time the Healthy Start risk screen is administered, the provider may indicate on the risk screening form that the member or infant is invited to participate based on factors other than score; or
- If the determination is made subsequent to risk screening, the provider may refer the member or infant directly to the Healthy Start care coordinator based on assessment of actual or potential factors associated with high risk, such as Human Immunodeficiency Virus (HIV), Hepatitis B, substance abuse or domestic violence.

All infants, children under the age of five, and pregnant, breast-feeding, and postpartum women will be referred to the local WIC office. Molina providers must provide:

- A completed Florida WIC program medical referral form with the current height or length and weight (taken within 60 days of the WIC appointment);
- Hemoglobin or hematocrit; and
- Any identified medical/nutritional problems.

Providers must coordinate with the local WIC office to provide the above referral data from the most recent Well Child visit. For every WIC referral form completed, the provider must give a copy of the form to the member and keep a copy in the member's medical record.

HIV testing

Molina providers must offer all women of childbearing age HIV counseling and HIV testing at the initial prenatal care visit and again at 28 and 32 weeks. If the member declines an HIV test, providers must obtain a signed objection.

Providers must offer counseling to all pregnant members who are HIV positive on the latest antiretroviral regimen recommended by the U.S. Department of Health & Human Services.

Hepatitis B testing

All pregnant members receiving prenatal care must be screened for the Hepatitis B surface antigen (HBsAg) during the first prenatal visit. A second HBsAg test must be conducted between 28 and 32 weeks of pregnancy for all members who tested negative at the first prenatal visit and are considered high risk for Hepatitis B infection.

Any HBsAg-positive women shall be reported to the local CHD and to Healthy Start, regardless of their Healthy Start screening score.

Infants born to HBsAg-positive members shall receive Hepatitis B Immune Globulin (HBIG) and the Hepatitis B vaccine once they are physiologically stable preferably within 12 hours of birth and shall complete the Hepatitis B vaccine series according to the vaccine schedule established by the Recommended Childhood Immunization Schedule for the United States. Infants born to HBsAg-positive members must be tested for HBsAg and Hepatitis B surface antibodies (anti-HBs) six months after the completion of the vaccine series for success or failure of the therapy. Any child age 24

months or less (<24) who tests positive for HBsAg must be reported to the local CHD within 24 hours of the positive test results.

Infants born to members who are HBsAg-positive shall be reported to the local CHD and Healthy Start regardless of their Healthy Start screening score.

Molina providers must report all prenatal or postpartum members who test HBsAg-positive to the Perinatal Hepatitis B Prevention Coordinator at the local CHD utilizing the Practitioner Disease Report Form (DH- 2136).

Reporting must include the following information:

- Name
- Date of birth
- Race/Ethnicity
- Address
- Infants
- Contacts
- Laboratory test(s) performed and date the sample was collected
- The due date or estimated date of confinement,
- Whether the member received prenatal care, and
- Immunization dates for infants and contacts

Telehealth and telemedicine services

You may obtain physical and behavioral health by Participating Providers, through the use of Telehealth and Telemedicine services. Not all Participating Providers offer these services. For more information, please refer to Telehealth and Telemedicine services in the definitions section. The following additional provisions apply to the use of Telehealth and Telemedicine services:

1. Telemedicine services provided under Florida Medicaid must be performed by licensed practitioners within their scope of practice;
2. Telemedicine services must involve the use of interactive telecommunications equipment which includes, at a minimum, audio and video equipment permitting two-way, real time, communication between the enrollee and the practitioner; and
3. Telephone conversations, chart review, electronic mail messages, or facsimile transmissions are not considered telemedicine.

When providing services through telemedicine, the Managed Care Plan shall ensure:

1. The telecommunication equipment and telemedicine operations meet the technical safeguards required by 45 CFR 164.312, where applicable;
2. The Managed Care Plan's providers using telemedicine comply with HIPAA and other state and federal laws pertaining to patient privacy;
3. The Managed Care Plan's telemedicine policies and procedures comply with the requirements in this Contract; and
4. Provider training regarding the telemedicine requirements in this Contract.

When telemedicine services are provided, the Managed Care Plan shall ensure that the enrollee's medical/case record includes documentation, as applicable. For more information, please review the Medical/Case Record Requirements section of this Provider Manual.

Medicaid does not reimburse for the costs or fees of any of the equipment necessary to provide services through telemedicine, including telecommunication equipment and services. The enrollee has a choice of whether to access services through a face-to-face or telemedicine encounter.

All Molina providers that wish to provide this service must attest that they have reviewed and meet these requirements in order to offer Virtual Health. The Telehealth Attestation is found on Molina's website at:
molinahealthcare.com/providers/fl/medicaid/forms/fuf.aspx

7. Healthcare services

Introduction

Health Care Services (HCS) is comprised of Utilization Management (UM) and Care Management (CM) departments that work together to achieve an integrated model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. Molina provides care management services to Members to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Elements of the Molina utilization management program include pre-service authorization review and inpatient authorization management that includes pre-admission, admission and concurrent review, medical necessity review, and restrictions on the use of out-of-network or non-participating Providers.

Utilization Management (UM)

Molina ensures the service delivered is medically necessary and demonstrates an appropriate use of resources based on the level of care needed for a Member. This program promotes the provision of quality, cost-effective, and medically appropriate services offered across a continuum of care and integrates a range of services appropriate to meet individual needs. Molina's UM program maintains flexibility to adapt to changes in the Member's condition and is designed to influence the Member's care by:

- Managing available benefits effectively and efficiently while ensuring quality care.
- Evaluating the medical necessity and efficiency of health care services across the continuum of care.
- Defining the review criteria, information sources, and processes that are used to review and approve the provision of items and services, including prescription drugs.
- Coordinating, directing, and monitoring the quality and cost effectiveness of health care resource utilization.
- Implementing comprehensive processes to monitor and control the utilization of health care resources.
- Ensuring services are available in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness.
- Reviewing processes to ensure care is safe and accessible.
- Ensuring qualified health care professionals perform all components of the UM processes.
- Ensuring UM decision making tools are appropriately applied in determining medical necessity decision.

Key functions of the UM program

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

- Eligibility and oversight
  - Eligibility Verification
  - Benefit Administration and Interpretation
  - Verification that authorized care correlates to Member's medical necessity need(s) and benefit plan
  - Verifying of current physician/hospital contract status
- Resource management
  - Prior Authorization and referral management

    - Pre-admission, Admission, and Inpatient Review
    - Referrals for Discharge Planning and Care Transitions
    - Staff education on consistent application of UM functions
- Quality Management
    - Satisfaction evaluation of the UM program using Member and Provider input
    - Utilization data analysis
    - Monitor for possible over- or under-utilization of clinical resources
    - Quality oversight
    - Monitor for adherence to CMS, NCQA, State and health plan UM standards

For more information about Molina's UM program, or to obtain a copy of the HCS Program description, clinical criteria used for decision making, and how to contact a UM reviewer, access the Molina website or contact the UM department.

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

UM decisions

A decision is any determination made by Molina or the delegated Medical Group/IPA or other delegated entity with respect to the following:

- Determination to authorize, provide or pay for services (favorable determination);
- Determination to delay, modify, or deny authorization or payment of request (adverse determination);
- Discontinuation of a payment or authorization for a service;

Molina follows a hierarchy of medical necessity decision making with Federal and State regulations taking precedence. Molina covers all services and items required by State and Federal regulations.

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

Requests for authorization not meeting criteria are reviewed by a designated Molina Medical Director or other appropriate clinical professional. Only a licensed physician or pharmacist, doctoral level clinical psychologist or certified addiction medicine

specialist as appropriate may determine to delay, modify, or deny payment or authorization of services to a Member.

Providers can contact Molina's Healthcare Services department at (855) 322-4076 to obtain Molina's UM Criteria.

Where applicable, Molina Corporate Policies can be found on the public website at MolinaClinicalPolicy.com. Please note that Molina follows state-specific criteria, if available, before applying Molina-specific criteria.

Medical necessity

"Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the Agency is the final arbiter of medical necessity. In making determinations of medical necessity, the Agency must, to the maximum extent possible, use a physician in active practice, either employed by or under contract with the Agency, of the same specialty or subspecialty as the physician under review. Such determination must be based upon the information available at the time the goods or services were provided.

For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

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.

Molina has processes for authorization of any medically necessary service to enrollees under the age of 21, in accordance with Section 1905(a) of the Social Security Act, when:

1. The service is not listed in the service-specific Florida Medicaid Coverage and Limitations Handbook (as found on the AHCA website), Florida Medicaid Coverage Policy, or the associated Florida Medicaid fee schedule, or
2. Is not a covered service of the plan; or
3. The amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.

Such services should be requested using the standard processes and should include any and all medical necessity support documentation.

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

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

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

The fact that a Provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

MCG Cite for Guideline Transparency and MCG Cite AutoAuth

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

- Transparency – delivers medical determination transparency
- Access – clinical evidence that payers use to support Member care decisions
- Security – ensures easy and flexible access via secure web access.

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

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

Cite AutoAuth can be accessed via the Availity portal and is available 24 hours per day/7 days per week. This method of submission is strongly encouraged as the primary submission route, the existing fax process will also be available for advanced imaging requests. Molina will also be rolling out additional services throughout the year. Clinical information submitted with prior authorization will be reviewed by Molina. This system will provide quicker and more efficient processing of your authorization request and the status of the authorization will be available immediately upon completion of your submission.

What is Cite AutoAuth and how does it work?

By attaching the relevant care guideline content to each prior authorization request and sending it directly to Molina, health care providers receive an expedited, often immediate response. Through a customized rules engine, Cite AutoAuth compares Molina's specific criteria to the clinical information and attached guideline content to the procedure to determine the potential for auto authorization.

Self-services available in the Cite AutoAuth tool include but are not limited to MRIs, CTs and PET scans. For a full list of imaging codes that require prior authorization, refer to the Prior Authorization Code LookUp Tool at MolinaHealthcare.com.

Medical necessity review

Molina only reimburses for services that are Medically Necessary. Medical Necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively. To determine Medical Necessity, in conjunction with independent professional medical judgment, Molina will use nationally recognized evidence-based guidelines, third party guidelines, CMS guidelines, state guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.

Levels of administrative and clinical review

The Molina review process begins with administrative review followed by clinical review if appropriate. Administrative review includes verifying eligibility, appropriate vendor or Participating Provider, and benefit coverage. The Clinical review includes medical necessity and level of care.

All UM requests that may lead to a medical necessity denial are reviewed by a health care professional at Molina (medical director, licensed pharmacist, or appropriately licensed health professional).

Molina's Provider training includes information on the UM processes and Authorization requirements.

Clinical information

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

Prior authorization

Molina requires prior authorization for specified services as long as the requirement complies with federal or state regulations and the Provider Agreement with Molina. The list of services that require prior authorization is available in narrative form, along with a more detailed list by Current Procedural Terminology (CPT®) and Healthcare Common Procedural Coding System (HCPCS) codes. Molina prior authorization documents are customarily updated quarterly but may be updated more frequently as appropriate and are posted on the Molina website at MolinaHealthcare.com.

CPT® is a registered trademark of the American Medical Association.

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

- Member demographic information (name, date of birth, Molina ID number).
- Provider demographic information (referring Provider and referred to Provider/facility, including address and NPI number).
- Member diagnosis and ICD-10 codes.
- Requested service/procedure, including all appropriate CPT and HCPCS codes.
- Location where service will be performed.
- Clinical information sufficient to document the medical necessity of the requested service is required including:

- Pertinent medical history (including treatment, diagnostic tests, examination data).
- Requested length of stay (for inpatient requests).
- Rationale for expedited processing.

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State Law) are excluded from the prior authorization requirements. Obtaining authorization does not guarantee payment. Molina retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care. Molina does not retroactively authorize services that require PA.

Molina makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the Member's clinical situation. The definition of expedited/urgent is when the situation where the standard time frame or decision making process could seriously jeopardize the life or health of the Member, the health or safety of the Member or others, due to the Member's psychological state, or in the opinion of the Provider with knowledge of the Member's medical or behavioral health condition, would subject the Member to adverse health consequences without the care or treatment that is subject of the request or could jeopardize the Member's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

For expedited organization determinations/pre-service authorization request, Molina will make a determination as promptly as the Member's health requires and no later than contractual requirements or two (2) calendar days after we receive the initial request for service in the event a provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a Member's life or health. For a standard authorization request, Molina makes the determination and provides notification no later than contractual requirements or seven (7) calendar days after we receive the initial request for service.

Information generally required to support the decision-making process includes:

- Adequate patient history related to the requested services
- Physical examination that addresses the area of the request
- Supporting lab and/or X-ray results to support the request
- Relevant PCP and/or Specialist progress notes or consultations

Providers who request prior authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina has a full-time Medical Director available to discuss medical necessity decisions with the requesting Provider at (855) 322-4076.

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone or fax. If a request is denied, the requestor and the Member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the Provider by telephone if at all possible or by fax with confirmation of receipt if telephonic communication fails.

Evolent

Molina collaborates with Evolent (formerly known as New Century Health) to conduct medical necessity review on certain prior authorization (PA) requests.

PA requests for Participating Servicing Providers are to be submitted to Evolent for professional service review and decisions for Molina adult Members ages 21 and over.

All out-of-network Servicing Provider PA requests and PA requests for Molina Members under the age of 21 will be reviewed by Molina.

Evolent conducts reviews for the following professional services:

Cardiology

- Non-Invasive Cardiology
- Non-Invasive Vascular
- Cardiac Cath and Interventional Cardiology
- Vascular Radiology and Intervention
- Vascular Surgery
- Thoracic Surgery
- Cardiac Surgery
- Electrophysiology

Please consult the PA Lookup Tool for further guidance on where to submit professional services PA requests.

For inpatient service requests, once approved by Evolent, the inpatient status will be reviewed by Molina upon notification of the admission. The inpatient admission and length of stay will be determined by Inpatient Utilization Management (Concurrent Review) at the time of hospitalization. Providers are to follow Molina's inpatient

notification process as you do today, and the continued stay will be reviewed for medical necessity and a decision made at that time.

Medical Oncology

Cancer Related Diagnoses: C00-D09.0, D37.01-D49.9, D61.810, D61.82, D63.0, D64.0-D64.81, D70.1, D72.822, D75.81, E34.0

Infused, injectable and oral* chemotherapy, hormonal therapeutic treatment, supportive agents, and symptom management medications.

**Pharmacy benefit single oral agent requests are out of scope for Evolent and pre-authorization must be obtained from Molina or applicable Pharmacy Benefits Manager (PBM). For Marketplace Members, Pharmacy benefits oral agents submitted in a request combined with infused/injectable cancer agents will be reviewed by Evolent for preauthorization.*

Radiation Oncology

Cancer Related Diagnoses: C00-D09.0, D37.01-D49.9, D61.810, D61.82, D63.0, D64.0-D64.81, D70.1, D72.822, D75.81, E34.0

- Brachytherapy
- Conformal
- IMRT (Intensity-modulated radiation therapy)
- SBRT (Stereotactic Body Radiation Therapy)
- IGRT (Image-guided radiation therapy)
- 2D, 3D (2 or 3 dimensional)
- SRS (Stereotactic radiosurgery)
- Radiopharmaceuticals
    - Proton and Neutron Beam Therapy

CAR-T

For inpatient CAR-T service requests, the inpatient status will be approved when medical necessity criteria is met, simultaneously with the approval of the CAR-T professional service(s) being reviewed.

The inpatient admission length of stay (where CAR-T is in scope) will be determined by Inpatient Utilization Management (Concurrent Review) at the time of any needed hospitalization. Providers are to follow Molina's inpatient notification process as you do today, and the continued stay will be reviewed for medical necessity and a decision made at that time. If other services are being performed during the inpatient stay that are unrelated to the CAR-T procedures, a separate authorization will need to be

completed through Molina's standard prior authorization process for medical necessity determination.

PA request submission

The requesting in-network Provider must complete a PA request using one of the following methods:

- For Providers' convenience, logging into the Evolent Provider Web Portal is the preferred submission method: my.newcenturyhealth.com
- Evolent's Provider Web Portal functionality offers instant approvals for PA requests

- Evolent Tel: (888) 999-7713, Option 1 Cardiology, Option 2 Medical Oncology, Option 3 Radiation Oncology

- Evolent Fax intake: Molina Cardiology: 1877-370-0963, Molina Medical Oncology: 1877-230-4493, Molina Radiation Oncology: 1877-380-7848

Providers should call the Evolent Network Operations department at (888) 999-7713, Option 6, with questions or for assistance with access/training on the Evolent Provider Web Portal.

Evolent: Retro-authorization

All retro-authorization* and extenuating circumstances reviews should be sent to Molina following the process you use today. The 30-day authorization reconsideration process excludes all the above-listed cardiology professional services based on our partnership with Evolent.

**For cardiology, Providers can submit same-day diagnostic and procedure authorization requests up to 10 business days from the date of service (DOS)/treatment start date (TSD). Procedure must meet medical necessity criteria.*

Peer-to-peer review

Upon receipt of an adverse determination, the Provider (peer) may request a peer-to-peer discussion within five (5) business days of the decision.

A "peer" is considered a physician, physician assistant, or nurse practitioner who is directly providing care to the Member. Contracted external parties, administrators, or

facility UM staff can request that a peer-to-peer telephone communication be arranged and performed but the discussion should be performed by a peer.

When requesting a peer-to-peer discussion, please be prepared with the following information:

- Member name and ID#
- Auth ID#
- Requesting Provider Name and contact number, best times to call

If a Medical Director is not immediately available, the call will be returned within two business days. Every effort will be made to return calls as expeditiously as possible.

Evolent: peer-to-peer review

Peer-to-peer review will be conducted by Evolent via physician discussions with expanded collaboration to better discuss treatment plans.

Providers are strongly encouraged to take advantage of Evolent's streamlined peer-to-peer process to hold timely conversations related to requested services.

Requesting prior authorization

Notwithstanding any provision in the Provider Agreement that requires Provider to obtain a prior authorization directly from Molina, Molina may choose to contract with external vendors to help manage prior authorization requests.

For additional information regarding the prior authorization of specialized clinical services, please refer to the Prior Authorization tools located on the MolinaHealthcare.com website:

- Prior Authorization Code Look-up Tool
- Prior Authorization Code Matrix
- Prior Authorization Guide

The most current Prior Authorization Guidelines and the Prior Authorization Request Form can be found on the Molina website at MolinaHealthcare.com/medicaid/providers/fl/forms/Pages/fuf.aspx.

Availity portal: Participating Providers are encouraged to use the Availity portal for prior authorization submissions whenever possible. Instructions for how to submit a

prior authorization request are available on the Availity portal. The benefits of submitting your prior authorization request through the Availity portal are:

- Create and submit Prior Authorization Requests.
- Check status of Authorization Requests.
- Receive notification of change in status of Authorization Requests.
- Attach medical documentation required for timely medical review and decision making.

Fax: The Prior Authorization Request Form can be faxed to Molina at:

- Prior Authorizations and Admissions – (866) 440-9791
- Transplant Authorizations – (877) 813-1206
- Advanced Imaging – (877) 731-7218

Phone: Prior authorizations can be initiated by contacting Molina's Healthcare Services department at (855) 322-4076. It may be necessary to submit additional documentation before the authorization can be processed.

Open communication about treatment

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

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

Delegated utilization management Functions

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

Communication and availability to Members and Providers

HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff by calling (855) 322-4076 during normal business hours, Monday through Friday (except for holidays) from 8:00 a.m. to 7:00 p.m.

Molina offers TTY/TDD services at: 711 for Members who are deaf, hard of hearing, or speech impaired. Language assistance is also always available for Members.

After business hours, Providers can also utilize fax and the Availity portal for UM access.

Molina's 24-hour Nurse Advice Line is available to Members 24 hours a day, seven days a week at:

HEALTHLINE 24-Hour Nurse Advice Line
English Phone: (888) 275-8750 Spanish Phone: (866) 648-3537
TTY: (866) 735-2929 or 711 (English) (866) 833-4703 (Spanish)

Molina's Nurse Advice Line may handle after-hours UM calls.

Emergency services

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

Emergency Services are covered on a 24-hour basis without the need for prior authorization for all Members experiencing an emergency medical condition.

Post-stabilization care services are covered services that are:

1. Related to an emergency medical condition
2. Provided after the Member is stabilized
3. Provided to maintain the stabilized condition or under certain circumstances, to improve or resolve the Member's condition

Providers requesting an in-patient admission as a post-stabilization service must request this type of service by contacting Molina at (855) 322-4076.

Inpatient admission requests (not including post-stabilization requests) received via fax will be processed within standard inpatient regulatory and contractual time frames.

Molina also provides Members with a 24-hour Nurse Advice Line for medical advice. The 911 information is given to all Members at the onset of any call to the plan.

For Members within our service area, Molina contracts with vendors that provide 24-hour Emergency Services for ambulances and hospitals. An out-of-network emergency hospital stay will be covered until the Member has stabilized sufficiently to transfer to a participating facility. Services provided after stabilization in a non-participating facility are not covered and the Member will be responsible for payment.

Molina care managers will contact Members over-utilizing the emergency department to provide assistance whenever possible and determine the reason for using emergency services.

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

Inpatient management

Planned admissions

Molina requires prior authorization for all elective/scheduled inpatient admissions and procedures to any facility. Facilities are required to also notify Molina within 24 hours or by the following business day once admission has occurred for concurrent review. Elective inpatient admission services performed without prior authorization may not be eligible for payment.

Emergent inpatient admissions

Molina requires notification of all emergent inpatient admissions within 24 hours of admission or by the following business day. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. Molina requires that notification includes Member demographic information, facility information, date of admission and clinical information sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting admission notification,

medical necessity requirements or failure to include all of the needed clinical documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient stay.

Inpatient at time of termination of coverage

If a Member's coverage with Molina terminates during a hospital stay, all services received after their termination of eligibility are not covered services, unless Law or Government Program requirements mandate otherwise.

Inpatient/concurrent review

Molina performs concurrent inpatient review to ensure the medical necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. Molina will request updated clinical records from inpatient facilities at regular intervals during a Member's inpatient stay. Molina requires that requested clinical information updates be received by Molina from the inpatient facility within 24 hours of the request.

Failure to provide timely clinical information updates may result in denial of authorization for the remainder of the inpatient admission dependent on the Provider contract terms and agreements. Molina will authorize hospital care as an inpatient, when the clinical record supports the medical necessity for the need for continued hospital stay. It is the expectation that observation has been tried in those patients that require a period of treatment or assessment, pending a decision regarding the need for additional care, and the observation level of care has failed. Upon discharge the Provider must provide Molina with a copy of the Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

Inpatient status determinations

Molina's UM staff follow CMS guidelines to determine if the collected clinical information for requested services is "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member" by meeting all coverage, coding, and medical necessity requirements (refer to the Medical Necessity Review section of this Provider Manual).

Discharge planning

The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission.

UM staff work closely with the hospital discharge planners to determine the most appropriate discharge setting for our Members. The clinical staff review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Readmissions

Readmission review is an important part of Molina's Quality Improvement (QI) program to ensure that Molina Members are receiving hospital care that is compliant with nationally recognized guidelines as well as Federal and State regulations.

Molina will conduct readmission reviews when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates.

When a subsequent admission to the same facility with the same or similar diagnosis occurs within 24 hours of discharge, the hospital will be informed that the readmission will be combined with the initial admission and will be processed as a continued stay.

When a subsequent admission to the same facility occurs within 2-30 days of discharge, and it is determined that the readmission is related to the first admission and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions. A Readmission is considered potentially preventable if it is clinically related to the prior admission and includes the following circumstances:

- Premature or inadequate discharge from the same hospital.
- Issues with transition or coordination of care from the initial admission.
- For an acute medical complication plausibly related to care that occurred during the initial admission.

- Readmissions that are excluded from consideration as preventable readmissions include:
  - Planned readmissions associated with major or metastatic malignancies, multiple traumas and burns.
  - Neonatal and obstetrical Readmissions.
  - Initial admissions with a discharge status of "left against medical advice" because the intended care was not completed.
  - Behavioral Health readmissions.

- Transplant related readmissions.

Post-service review

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

Affirmative statement about incentives

All medical decisions are coordinated and rendered by qualified physicians and licensed staff unhindered by fiscal or administrative concerns. Molina and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to Members.

Molina requires that all utilization-related decisions regarding Member coverage and/or services are based solely on appropriateness of care and service and existence of coverage. Molina does not specifically reward Practitioners or other individuals for issuing denials of coverage or care. Molina does not receive financial incentives or other types of compensation to encourage decisions that result in underutilization. Out-of-network providers and services

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

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

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

Coordination of care and services

Molina HCS staff work with Providers to assist with coordinating referrals, services and benefits for Members who have been identified for Molina's Integrated Care Management (ICM) program via assessment or referral such as, self-referral, Provider referral, etc. In addition, the coordination of care process assists Molina Members, as necessary, in transitioning to other care when benefits end.

Molina staff provide an integrated approach to care needs by assisting Members with identification of resources available to the Member, such as community programs, national support groups, appropriate specialists, and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with Providers, Members and/or their authorized representative(s) to ensure efforts are efficient and non-duplicative.

Continuity of care and transition of Members

It is Molina's policy to provide Members with advance notice when a Provider they are seeing will no longer be in-network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the Provider(s) assuming care.

Molina will notify Members in active care at least 60 days before the termination date of the provider and allow Members to continue receiving services from the terminated provider for a minimum of 60 days after the termination date. Continuation of care may not exceed six months after the termination date of the provider.

Molina Members involved in an active course of treatment have the option to complete treatment with the Provider who initiated care for the first 60 calendar days from the date of the member's enrollment. The lack of a contract with the Provider of a new Member or terminated contracts between Molina and a Provider will not interfere with this option.

Molina shall continue the entire course of treatment with the recipient's current Provider for the following services which may extend beyond 60 days continuity of care period:

- Prenatal and postpartum care
- Transplant services
- Oncology (Radiation and/or Chemotherapy services from the current round of treatment)
- Full course of therapy Hepatitis C treatment drugs

Pregnant Members who have initiated a course of prenatal care may continue to receive care from a terminated provider through the completion of pregnancy and postpartum period, regardless of the trimester in which care was initiated.

Requests for continued care should be submitted to the Utilization Management Department at:

Phone: (855) 322-4076
Fax: (866) 440-9791

Continuity of Care may not apply if a Provider is terminated for cause.

Continuity and coordination of Provider communication

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

24-Hour Telephonic Coverage

The network Providers listed below are required to have 24-hour telephonic coverage:

- Assisted Living Facilities
- Emergency Response Systems
- Nursing Homes

Reporting of suspected abuse, exploitation and/or neglect

A vulnerable adult is a person who is receiving or may be in need of receiving community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of themself or unable to protect themself against significant harm or exploitation. When working with children one may

encounter situations suggesting abuse, neglect and/or unsafe living environments. Providers must immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline toll-free telephone number, (800) 96ABUSE. Additionally, all Providers, including HCBS Providers, must report adverse incidents including events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing, or major medication incidents to Molina immediately. For HCBS Providers, Critical Incidents must be reported no more than 24 hours of the incident. For MMA providers, Adverse Incidents must be reported no more than 48 hours of the incident.

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

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

Documentation related to the suspected abuse, neglect, or exploitation, including the reporting of such, must be kept in a confidential file, separate from the enrollee record. Providers must make the file available to Molina or any other State or Federal Agency upon request.

The Critical Incident Form is located on Molina's website at:

MolinaHealthcare.com/providers/fl/medicaid/forms/fuf.aspx

To report a critical incident, Provider should email the Critical Incident Form to

MFLQIAlerts@MolinaHealthcare.com

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

have been abused, exploited, or neglected to ensure appropriate measures were taken, and follow up on safety issues. Molina will track, analyze, and report aggregate information regarding abuse reporting to the Health Care Services Committee and the proper State agency.

All Molina direct service providers must complete Abuse, Neglect, and Exploitation Training. This training may be provided by the Department of Children and Families, the local area agency on aging, the Department of Elder Affairs, or through licensing requirements. Suspected abuse and/or neglect should be reported as follows:

Department of Children and Families
1317 Winewood Blvd
Bldg 1 – Room 202
Tallahassee, FL 32399-0700

Phone: (850) 487-1111
Fax: (850) 922-2993

More information on Abuse, Neglect or Exploitation can be found on the Department of Children & Families website at: myflfamilies.com/service-programs/abuse-hotline/report-online.

Critical/adverse incident reporting exceptions for MMA

Molina does not require Critical Incident reporting from the following providers:

- Health Maintenance Organizations and Health Care Clinics reporting in accordance with s. 641.55, F.S.;
- Ambulatory Surgical Centers and Hospitals reporting in accordance with s. 395.0197, F.S.;
- Assisted Living Facilities reporting in accordance with s. 429.23, F.S.;
- Nursing Facilities reporting in accordance with s. 400.147, F.S.;
- Crisis Stabilization Units, Residential Treatment Centers for children and adolescents, and Residential Treatment Facilities reporting in accordance with s. 394.459, F.S.,

Critical Incidents occurring in these licensed settings shall be reported in accordance with the facility's licensure requirements.

Critical/adverse incident reporting exceptions for LTC

Molina Healthcare does not require Critical Incident reporting from the following HCBS Providers:

- Nursing Facilities reporting in accordance with s. 400.147, F.S.;
- Assisted Living Facilities reporting in accordance with s. 429.23, F.S.

Critical incidents occurring in nursing facilities and ALFs will be addressed in accordance with Florida law.

Identifying victims of human trafficking

The National Human Trafficking Hotline helps victims in crisis through safety planning, emotional support, and connections to local resources.

www.acf.hhs.gov/opre/topic/human-trafficking

Call 1-888-373-7888

Text: HELP to BEFREE (233733)

Email: help@humantraffickinghotline.org

Visit: www.humantraffickinghotline.org

PCP responsibilities in case management referrals

The Member's PCP is the primary leader of the health team involved in the coordination and direction of services for the Member. The case manager provides the PCP with the Member's individualized care plan (ICP), interdisciplinary care team (ICT) updates, and information regarding the Member's progress through the ICP when requested by the PCP. The PCP is responsible for the provision of preventive services and for the primary medical care of Members.

Case manager responsibilities

The case manager collaborates with the Member and any additional participants as directed by the Member to develop an ICP that includes recommended interventions from Member's ICT, as applicable. ICP interventions include the appropriate information to address medical and psychosocial needs and/or barriers to accessing care, care coordination to address Member's health care goals, health education to support self-management goals, and a statement of expected outcomes. Jointly, the

care manager and the Member/authorized representative(s) are responsible for implementing the plan of care. Additionally, the care manager:

- Assesses the Member to determine if the Member's needs warrant care management.

  Monitors and communicates the progress of the implemented ICP to the Member's ICT, as Member needs warrant.
- Serves as a coordinator and resource to the Member, their representative and ICT participants throughout the implementation of the ICP, and revises the plan as suggested and needed.
- Coordinates appropriate education and encourages the Member's role in self-management.
- Monitors progress toward the Member's achievement of ICP goals to determine an appropriate time for the Member's graduation from the ICM program.

Health management

The tools and services described here are educational support for Molina Members and may be changed at any time as necessary to meet the needs of Molina Members. Level 1 Members can be engaged in the program for up to 60 days depending on Member preferences and the clinical judgement of the Health Management team.

Level 1 Health Management

Molina offers programs to help our Members and their families manage various health conditions. The programs include telephonic outreach from our clinical staff and health educators that includes condition specific triage assessment, care plan development and access to tailored educational materials. Members are identified via Health Risk Assessments (HRA) and identification and stratification. You can also directly refer Members who may benefit from these program offerings via Molina's Case Management department. Members can request to be enrolled or disenrolled in these programs at any time. Our Molina My Health programs include:

- Living with Asthma
- Living with Diabetes
- Living with High Blood Pressure
- Living with Heart Failure (HF)
- Living with COPD
- Living with Depression
- Weight Management

- Tobacco Cessation
- Nutrition

For more information about these programs, please call (833) 269-7830 (TTY/TDD: 711 Relay) or fax (800) 642-3691.

Maternity screening and high-risk obstetrics

Molina offers to all pregnant members prenatal health education with resource information as appropriate and screening services to identify high risk pregnancy conditions. Care managers with specialized OB training provide additional care coordination and health education for members with identified high risk pregnancies to assure best outcomes for members and their newborns during pregnancy, delivery and through their 6th week post-delivery. Pregnant member outreach, screening, education, and care management are initiated by provider notification to Molina, Member self-referral and internal Molina notification processes. Providers can notify Molina of pregnant/ high risk pregnant members via faxed Pregnancy Notification Report Forms.

Pregnancy notification process

The PCP shall submit to Molina the Pregnancy Notification Report Form (available at MolinaHealthcare.com) within one (1) working day of the first prenatal visit and/or positive pregnancy test. The form should be faxed to Molina at (239) 236-8409.

Member newsletters

Member Newsletters are posted on the MolinaHealthcare.com website at least once a year. The articles are about topics asked by Members. The tips are aimed to help Members stay healthy.

Member health education materials

Members can access our easy-to-read evidenced-based educational materials about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes, depression, and other relevant health topics identified during our engagement with Members. Materials are available through the Member Portal, direct mail as requested, email, and the My Molina mobile app.

Program eligibility criteria and referral source

Health Management (HM) Programs are designed for Molina Members with a confirmed diagnosis. Identified Members will receive targeted outreach such as educational materials, telephonic outreach, or other materials to access information on their condition. Members can contact Molina Member Services at any time and request to be removed from the program.

Members may be identified for or referred to HM programs from multiple pathways which may include the following:

- Pharmacy Claims data for all classifications of medications.
- Encounter Data or paid Claims with a relevant CMS-accepted diagnosis or procedure code.
- Member Services welcome calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry.
- Member Assessment calls made by staff for the initial Health Risk Assessments (HRA) for newly enrolled Members.
- External referrals from Provider(s), caregivers, or community-based organizations.
- Internal referrals from Nurse Advice Line, Medication Management, or Utilization Management.
- Member self-referral due to general plan promotion of program through Member newsletter or other Member communications.

Provider participation

Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease.
- Clinical resources such as patient assessment forms and diagnostic tools.
- Patient education resources.
- Provider Newsletters promoting the Health Management Programs, including how to enroll patients and outcomes of the programs.
- Clinical Practice Guidelines
- Preventive Health Guidelines
- Case Management collaboration with the Member's Provider
- Faxing a Provider Collaboration Form to the Member's Provider when indicated

Additional information on Health Management Programs is available from your local Molina HCS department.

Primary care providers

Molina provides a panel of PCPs to care for its Members. Providers in the specialties of Family Medicine, Internal Medicine and Obstetrics and Gynecology are eligible to serve as PCPs. Members may choose a PCP or have one selected for them by Molina. Molina's Members are required to see a PCP who is part of the Molina Network. Molina's Members may select or change their PCP by contacting Molina's Member & Provider Contact Center.

Specialty providers

Molina maintains a network of specialty Providers to care for its Members. Referrals from a Molina PCP are required for a Member to receive specialty services; however, no prior authorization is required. Members are allowed to directly access women health specialists for routine and preventive health without a referral for services.

Molina will help to arrange specialty care outside the network when Providers are unavailable or the network is inadequate to meet a Member's medical needs. To obtain such assistance contact the Molina UM department. Referrals to specialty care outside the network require prior authorization from Molina.

Care management (CM)

Molina provides a comprehensive ICM program to all Members who meet the criteria for services. The ICM program focuses on coordinating the care, services, and resources needed by Members throughout the continuum of care. Molina adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina case managers are licensed professionals and are educated, trained, and experienced in the ICM program. The ICM 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 ICM program is individualized to accommodate a Member's needs with collaboration and approval from the Member's PCP. The Molina case manager will assess the Member upon engagement after identification for ICM enrollment, assist

with arrangement of individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina case manager is responsible for assessing the Member's appropriateness for the ICM program and for notifying the PCP of ICM program enrollment, as well as facilitating and assisting with the development of the Member's ICP.

Referral to care management

Members with high-risk medical conditions and/or other care needs may be referred by their PCP, specialty care Provider, themselves, caregiver, discharge planner or Molina Healthcare Services to the ICM program. The case manager works collaboratively with the Member and all participants of the ICT when warranted, including the PCP and specialty Providers, such as discharge planners, ancillary providers, the local Health Department, and other community-based resources when identified. The referral source should be prepared to provide the case manager with demographic, health care, and social data about the Member being referred.

Members with the following conditions may qualify for case management and should be referred to the Molina ICM Program for evaluation:

- High-risk pregnancy, including Members with a history of a previous preterm delivery
- Catastrophic or end-stage medical conditions (e.g., neoplasm, organ/tissue transplants, End Stage Renal Disease)
- Comorbid chronic illness (e.g., asthma, diabetes, COPD, CHF, etc.)
- Home Health care
- Member accessing emergency department services inappropriately
- Children with Special Health Care Needs

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

Phone: (855) 322-4076
Fax: (866) 440-9791

Referrals may also be emailed to: MFLCaseManagement@Molinahealthcare.com.

8. Behavioral health

Overview

Molina provides a Behavioral Health benefit for Members. Molina takes an integrated, collaborative approach to behavioral health care, encouraging participation from

PCPs, behavioral health, and other specialty Providers to ensure whole person care. All provisions within the Provider Manual are applicable to medical and behavioral health Providers unless otherwise noted in this section.

Utilization management and prior authorization

Some behavioral health services may require prior authorization.

Behavioral Health inpatient and residential services can be requested by submitting a Prior Authorization form or contacting Molina's Prior Authorization team at (855) 322-4076. Providers requesting after-hours authorization for these services should utilize the Availity portal or fax submission options. Emergency psychiatric services do not require Prior Authorization. All requests for Behavioral Health services should include the most current version of Diagnostic and Statistical Manual of Mental Disorders (DSM) classification. Molina utilizes standard, generally accepted Medical Necessity criteria for Prior Authorization reviews. Please see the Prior Authorization subsection found in the Health Care Services section of this Provider Manual for additional information.

Access to behavioral health Providers and PCPs

Members may be referred to an in-network Behavioral Health Provider via referral from a PCP, medical specialist or by Member self-referral. PCPs are able to screen and assess Members for the detection and treatment of, or referral for, any known or suspected Behavioral Health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health service within the scope of their practice. A formal referral form or prior authorization is not needed for a Member to self-refer or be referred to a PCP, specialist or behavioral health Provider.

Behavioral Health Providers may refer a Member to an in-network PCP, or a Member may self-refer. Members may be referred to PCP and specialty care Providers to manage their health care needs. Behavioral Health Providers may identify other health concerns, including physical health concerns, that should be addressed by referring the Member to a PCP.

Care coordination and continuity of care

Discharge planning

Discharge planning begins upon admission to an inpatient or residential behavioral health facility. Members who were admitted to an inpatient or residential behavioral

health setting must have an adequate outpatient follow-up appointment scheduled with a behavioral health Provider prior to discharge and to occur within seven (7) days of the discharge date.

Interdisciplinary care coordination

In order to provide care for the whole person, Molina emphasizes the importance of collaboration amongst all Providers on the Member's treatment team. Behavioral Health, Primary Care, and other specialty Providers shall collaborate and coordinate care amongst each other for the benefit of the Member. Collaboration of the treatment team will increase communication of valuable clinical information, enhance the Member's experience with service delivery, and create opportunity for optimal health outcomes. Molina's Care Management program may assist in coordinating care and communication amongst all Providers of a Member's treatment team.

Care management

Molina's Care Management team includes licensed nurses and clinicians with behavioral health experience to support Members with mental health and SUD needs. Members with high-risk psychiatric, medical, or psychosocial needs may be referred by a behavioral health professional to the ICM program.

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

Phone: (855) 322-4076
Fax: (866) 440-9791
MFLCaseManagement@MolinaHealthcare.com and
mMFL-SP@Molinahealthcare.com.

Additional information on the ICM program can be found in the Care Management subsection found in the Health Care Services section of this Provider Manual.

Responsibilities of behavioral health Providers

Molina promotes collaboration with Providers and integration of physical and behavioral health services to provide quality care coordination to Members. Behavioral Health Providers are expected to provide in-scope, evidence-based mental health, and substance use disorder services to Molina Members. Behavioral Health Providers may only provide physical health care services if they are licensed to do so.

Providers shall follow Quality standards related to access. Molina provides oversight of Providers to ensure Members can obtain needed health services within the acceptable

appointment timeframes. Please see the Quality section of this Provider Manual for specific access to appointment details.

All Members receiving inpatient psychiatric services must be scheduled for a psychiatric outpatient appointment prior to discharge. The aftercare outpatient appointment must include the specific time, date, location, and name of the Provider. This appointment must occur within seven days of the discharge date. If a Member misses a behavioral health appointment, the Behavioral Health Provider shall contact the Member within 24 hours of a missed appointment to reschedule.

Behavioral Health Crisis Line

Molina has a Behavioral Health Crisis Line that may be accessed by Members 24/7 year-round. The Molina Behavioral Health Crisis Line is staffed by behavioral health clinicians to provide urgent crisis intervention, emergent referrals and/or triage to appropriate supports, resources, and emergency response teams. Members experiencing psychological distress may access the Behavioral Health Crisis Line by calling the Member Services telephone number listed on the back of their Molina Member ID card.

National Suicide Lifeline

988 is the National Suicide Lifeline. Anyone in need of suicide or mental health crisis support (or anyone with concerns about someone else), can receive free and confidential support 24 hours a day, 7 days a week, 365 days per year, by dialing 988 from any phone.

Behavioral Health Tool Kit for Providers

Molina has developed an online Behavioral Health Tool Kit to provide support with screening, assessment, and diagnosis of common behavioral health conditions, plus access to Behavioral Health HEDIS® Tip Sheets and other evidence-based guidance, and recommendations for coordinating care. The material within this tool kit is applicable to Providers in both medical and behavioral health settings. The Behavioral Health Tool Kit for Providers can be found under the “Health Resources” tab on the MolinaHealthcare.com Provider website.

9. Quality

Maintaining quality improvement processes and programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement (QI) program. You can contact the Molina Quality department (855) 322-4076 or fax (866) 440-9791.

The address for mail requests is:

Molina Healthcare of Florida, Inc.
Attn: Quality Department
8300 NW 33rd St, Suite 400
Doral, FL 33122

This Provider Manual contains excerpts from the Molina QI Program. For a complete copy of Molina's Quality Improvement Program, you can contact your Provider Services representative or call the telephone number above to receive a written copy.

Molina has established a Quality Improvement Program that complies with regulatory requirements and accreditation standards. The Quality Improvement Program provides structure and outlines specific activities designed to improve the care, service, and health of our Members. In our quality program description, we describe our program governance, scope, goals, measurable objectives, structure, and responsibilities.

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

- Have a Quality Improvement Program in place.
- Comply with and participate in Molina's Quality Improvement Program including reporting of Access and Availability survey and activity results and provision of medical records as part of the HEDIS® review process and during potential Quality of Care and/or Critical Incident investigations.
- Cooperate with Molina's quality improvement activities designed to improve quality of care and services and Member experience.
- Allow Molina to collect, use and evaluate data related to Provider performance for quality improvement activities, including focus areas such as clinical care, care coordination and management, service, and access and availability.
- Allow access to Molina Quality personnel for site and medical record review processes.

Patient safety program

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

Quality of care

Molina has established a systematic process to identify, investigate, review, and report any Quality of Care, Adverse Event/Never Event, Critical Incident (as applicable), and/or service issues affecting Member care. Molina will research, resolve, track, and trend issues. Confirmed Adverse Events/Never Events are reportable when related to an error in medical care that is clearly identifiable, preventable and/or found to have caused serious injury or death to a patient. Some examples of never events include:

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

Molina is not required to pay for inpatient care related to "never events."

Medical records

Molina requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member's record. PCPs should maintain the following medical record components, that include but are not limited to:

- Medical record confidentiality and release of medical records within medical and behavioral health care records.
- Medical record content and documentation standards, including preventive health care.
- Storage maintenance and disposal processes.

- Process for archiving medical records and implementing improvement activities.

Medical record keeping practices

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

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

Content

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

- Each page in the record contains the patient's name or ID number.
- Member name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact.
- Legible signatures and credentials of Provider and other staff members within a paper chart.
- All Providers who participate in the Member's care.
- SDOH assessments and referrals.
- Information about services delivered by these Providers.
- A problem list that describes the Member's medical and behavioral health conditions.
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.

- Medication reconciliation within 30 days of an inpatient discharge should include evidence of current and discharge medication reconciliation and the date performed.
- Allergies and adverse reactions (or notation that none are known).
- Documentation that Advance Directives, Power of Attorney and Living Will have been discussed with Member, and a copy of Advance Directives when in place.
- Past medical and surgical history, including physical examinations, treatments, preventive services, and risk factors.
- Treatment plans that are consistent with diagnosis.
- A working diagnosis recorded with the clinical findings.
- Pertinent history for the presenting problem.
- Pertinent physical exam for the presenting problem.
- Lab and other diagnostic tests that are ordered as appropriate by the Provider.
- Social Determinants of Health (SDOH) screenings or referrals, i.e. economic stability, education, environment.
- Clear and thorough progress notes that state the intent for all ordered services and treatments.
- Notations regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed, included in the next preventative care visit when appropriate.
- Notes from consultants if applicable.
- Up-to-date immunization records and documentation of appropriate history.
- All staff and Provider notes are signed physically or electronically with either name or initials.
- All entries are dated.
- All abnormal lab/imaging results show explicit follow up plan(s).
- All ancillary services reports.
- Documentation of all emergency care provided in any setting.
- Documentation of all hospital admissions, inpatient and outpatient, including the hospital discharge summaries, hospital history and physical and operative report.
- Labor and Delivery Record for any child seen since birth.
- A signed document stating with whom protected health information may be shared.

Organization

- The medical record is legible to someone other than the writer.
- Each patient has an individual record.
- Chart pages are bound, clipped, or attached to the file.
- Chart sections are easily recognized for retrieval of information.

- A release document for each Member authorizing Molina to release medical information for facilitation of medical care.

Retrieval

- The medical record is available to Provider at each encounter.
- The medical record is available to Molina for purposes of Quality improvement.
- The medical record is available to -the applicable State and/or Federal agency and the External Quality Review Organization upon request.
- The medical record is available to the Member upon their request.
- A storage system for inactive Member medical records which allows retrieval within 24 hours, is consistent with State and Federal requirements, and the record is maintained for not less than 10 years from the last date of treatment or for a minor, one year past their 20th birthday but, never less than 10 years.
- An established and functional data recovery procedure in the event of data loss.

Confidentiality

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

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

Additional information on medical records is available from your local Molina Quality department. For additional information regarding HIPAA, please see the Compliance section of this Provider Manual.

Advance directives (Patient Self-Determination Act)

Molina complies with the advance directive requirements of the States in which the organization provides services. Responsibilities include ensuring Members receive information regarding advance directives and that contracted Providers and facilities uphold executed documents.

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

- Durable Power of Attorney for Health Care: allows an agent to be appointed to carry out health care decisions.
- Living Will: allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration.

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

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

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

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

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

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

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

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

Access to care

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

Appointment access

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

Medical appointment

Appointment Types	Standard
Routine, asymptomatic	Within 30 calendar days
Routine, symptomatic	Within 30 calendar days
Urgent Care	Within 24 hours
After Hours Care	24 hours/day; 7 days/week availability
Specialty Care (High Volume)	Within 60 calendar days
Specialty Care (High Impact)	Within 60 calendar days
Urgent Specialty Care	Within 24 hours

Behavioral health appointment

Appointment Types	Standard
Life Threatening Emergency	Immediately
Non-life-Threatening Emergency	Within 6 hours
Urgent Care	Within 48 hours
Initial Routine Care Visit	Within 10 business days
Follow-up Routine Care Visit	Within 30 calendar days

Additional information on appointment access standards is available from your local Molina Quality department.

Office wait time

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

After hours

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a 24-hour telephone service, seven days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an Emergency to hang up and call 911 or go immediately to the nearest emergency room. Voicemail alone after-hours is not acceptable.

Appointment scheduling

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

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments.
2. A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record. If a second appointment is missed, the Provider is to notify the Molina Provider Services department toll free at (855) 322-4076 or TTY/TDD 711.

3. When the Provider must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time.
4. Special needs of Members must be accommodated when scheduling appointments. This includes but is not limited to wheelchair-using Members and Members requiring language interpretation.
5. A process for Member notification of preventive care appointments must be established. This includes but is not limited to immunizations and mammograms.
6. A process must be established for Member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

In applying the standards listed above, participating Providers have agreed that they will not discriminate against any Member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, gender identity, pregnancy, sex stereotyping, place of residence, socioeconomic status or status as a recipient of Medicaid benefits. Additionally, a participating Provider or contracted medical group/IPA may not limit their practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care. If a PCP chooses to close their panel to new Members, Molina must receive 30 calendar day advance written notice from the Provider.

Women's health access

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

Additional information on access to care is available from your local Molina Quality department.

Monitoring access for compliance with standards

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

Provider Network adherence to access standards is monitored via one or more of the following mechanisms:

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

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

Quality of provider office sites

Molina Providers are to maintain office-site and medical record keeping practices standards. Molina continually monitors Member appeals and complaints /grievances for all office sites to determine the need of an office site visit and will conduct office site visits as needed. Molina assesses the quality, safety, and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This includes an assessment of:

- Physical Accessibility
- Physical Appearance
- Adequacy of Waiting and Examining Room Space

Physical accessibility

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

Physical appearance

The site visits include, but are not limited to, an evaluation of office site cleanliness, appropriateness of lighting, and patient safety as needed.

Adequacy of waiting and examining room space

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

Administration and confidentiality of facilities

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

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

- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A CLIA waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double-locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

Early and periodic screening, diagnostic and treatment (EPSDT) services to enrollees under 21 years of age

Molina maintains systematic and robust monitoring mechanisms to ensure all required Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services to Enrollees under 21 years of age are timely according to required preventive guidelines. All Enrollees under 21 years of age should receive preventive, diagnostic and treatment services at intervals as set forth in Section 1905(R) of the Social Security Act. Molina's Quality or the Provider Services department is also 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.

Well Child/Adolescent Visits

Visits consist of age-appropriate components, that include but are not limited to:

- Comprehensive health and developmental history.
- Nutritional assessment.
- Height, weight and growth charting.
- Comprehensive unclothed physical examination.
- Appropriate immunizations according to the Advisory Committee on Immunization Practices.
- Laboratory procedures, including lead blood level assessment appropriate for age and risk factors.
- Periodic developmental and behavioral screening using a recognized, standardized developmental screening tool.
- Vision screening for preventive services. Only medically necessary services are covered. Pediatric routine vision services (one [1] eye exam per year) is accessed by Members.
- Hearing screening for preventive services.
- Dental assessment and services.

- Health education, including anticipatory guidance such as child development, healthy lifestyles, accident, and disease prevention.
- Periodic objective screening for social-emotional development using a recognized, standardized tool.
- Perinatal depression for mothers of infants in the most appropriate clinical setting, e.g., at the pediatric, behavioral health or OB/GYN visit.

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

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

Monitoring for compliance with standards

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

Quality Improvement activities and programs

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

Health management and care management

The Molina health management and care management programs provide for the identification, assessment, stratification, and implementation of appropriate interventions for Members with chronic diseases.

For additional information, please see the Health Management and Care Management headings in the Health Care Services section of this Provider Manual.

Clinical practice guidelines

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

Molina CPGs include the following:

- Acute Stress and Post-Traumatic Stress Disorder (PTSD)
- Anxiety/Panic Disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism
- Bipolar Disorder
- Children with Special Health Care Needs
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure in Adults
- Homelessness – Special Health Care Needs
- Hypertension
- Obesity
- Opioid Management
- Perinatal Care
- Pregnancy Management
- Schizophrenia
- Sickle Cell Disease
- Substance Abuse Treatment
- Suicide Risk
- Trauma-Informed Primary Care

All CPGs are updated at least annually and more frequently as needed when clinical evidence changes and are approved by the Quality Improvement and Health Equity Transformation Committee. A review is conducted at least monthly to identify new additions or modifications. On an annual basis, or when changes are made during the

year, CPGs are distributed to Providers at MolinaHealthcare.com and the Provider Manual. Notification of the availability of the CPGs is published in the Molina Provider Newsletter.

Preventive Health Guidelines

Molina provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF), Bright Futures/American Academy of Pediatrics and Centers for Disease Control and Prevention (CDC), in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include, but are not limited to:

- Adult Preventive Services Recommendations (U.S. Preventive Services Task Force). Links to current recommendations are included on Molina's website.
- Recommendations for Preventive Pediatric Health Care (Bright Futures/American Academy of Pediatrics). Links to current recommendations are included on Molina's website.
- Recommended Adult Immunization Schedule for ages 19 Years or Older (United States). These recommendations are revised every year by the CDC. Links to current recommendations are included on Molina's website.
- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger (United States). These recommendations are revised every year by the CDC. Links to current recommendations are included on Molina's website.

All preventive health guidelines are updated at least annually, and more frequently, as needed when clinical evidence changes, and are approved by the Quality Improvement Committee. On an annual basis, Preventive Health Guidelines are distributed to Providers at MolinaHealthcare.com and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Cultural and linguistic appropriate services

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

Measurement of clinical and service quality

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

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Behavioral Health Satisfaction Assessment
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Initiatives

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

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

Molina's most recent results can be obtained from your local Molina Quality department or by visiting our website at MolinaHealthcare.com.

HEDIS®

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

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

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

CAHPS®

CAHPS® is the tool used by Molina to summarize Member satisfaction with the Providers, health care and service they receive. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Customer Service, Rating of Health Care and Getting Needed Prescription Drugs. The CAHPS® survey is administered annually in the spring to randomly selected Members by an NCQA-certified vendor.

CAHPS® results are used in much the same way as HEDIS® results, only the focus is on the service aspect of care rather than clinical activities. They form the basis for several of Molina's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

Behavioral Health Satisfaction Assessment

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

Behavioral health satisfaction assessment

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

Provider satisfaction survey

Recognizing that HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey both focus on Member experience with health care Providers and health plans, Molina conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina, as this is one of the primary methods used to identify improvement areas pertaining to the Molina Provider Network. The survey results have

helped establish improvement activities relating to Molina's specialty network, inter-Provider communications, and pharmacy authorizations. This survey is fielded to a random sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of quality improvement initiatives

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

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

What can providers do?

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

Molina has additional resources to assist Providers and their patients. For access to tools that can assist, please visit the Availity portal. There are a variety of resources, including HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey Star Ratings measures, contact your local Molina Quality department.

HEDIS® and CAHPS® are registered trademarks of the National Committee for Quality Assurance (NCQA).

10. Risk adjustment management program

What is risk adjustment?

CMS defines Risk Adjustment as a process that helps accurately measure the health status of a plan's membership based on medical conditions and demographic information.

This process helps ensure health plans receive accurate payment for services provided to Molina members and prepares for resources that may be needed in the future to treat Members who have multiple clinical conditions.

Molina Healthcare of Florida's Risk Management Program strives to provide quality care and service to our members. Risk Management is an integrated, company-wide program for the prevention, monitoring, and control of areas of potential liability exposure. It is the intent of Molina Healthcare of Florida, via the Risk Management Program to enhance the safety of patients, visitors, and employees; and minimize the financial loss to Molina Healthcare of Florida through risk detection, evaluation, and prevention.

Molina Healthcare of Florida maintains a risk management process that is designed to assure that network providers possess the credentials, including training and experience, to provide members the level of quality of care consistent with the mission of Molina Healthcare of Florida.

The program focuses on identification and prevention of risk exposures within the organization that could:

- Cause injury to patients, visitors, and employees
- Jeopardize the safety and security of the environment
- Result in costly claims and lawsuits with subsequent financial loss to the organization

The Risk Management Program is administered by the Quality Improvement Department. The Chief Medical Director and Director of Quality Improvement are responsible for the implementation and operation of the Risk Management Program which reports quarterly to the Quality Assurance Committee and to the Molina Healthcare of Florida Board of Directors.

Why is risk adjustment important?

Molina relies on our Provider Network to care for our Members based on their health care needs. Risk Adjustment looks at a number of clinical data elements of a Member's health profile to determine any documentation gaps from past visits and identifies opportunities for gap closure for future visits. In addition, Risk Adjustment allows us to:

- Focus on quality and efficiency.
- Recognize and address current and potential health conditions early.
- Identify Members for case management referral.
- Ensure adequate resources for the acuity levels of Molina Members.
- Have the resources to deliver the highest quality of care to Molina Members.

Interoperability

Provider agrees to deliver relevant clinical documents (Clinical Document Architecture (CDA) or Continuity of Care Document (CCD) format) at encounter close for Molina Members by using one of the automated methods available and supported by Provider's Electronic Medical Records (EMR), including, but not limited to, Epic Payer Platform, Direct protocol, Secure File Transfer Protocol (sFTP), query or Web service interfaces such as Simple Object Access Protocol (External Data Representation) or Representational State Transfer (Fast Healthcare Interoperability Resource). CCDA or CCD document should include signed clinical note or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) CCDA standard.

Provider will also enable HL7 v2 Admission/Discharge/Transfer (ADT) feed for all patient events for Molina Members to the interoperability vendor designated by Molina.

Provider will participate in Molina's program to communicate Clinical Information using the Direct Protocol. Direct Protocol is the Health Insurance Portability and Accountability Act (HIPAA) compliant mechanism for exchanging health care information that is approved by the Office of the National Coordinator for Health Information Technology (ONC).

- If Provider does not have a Direct Address, Provider, will work with its EMR vendor to set up a Direct Messaging Account, which also supports the Centers for Medicare & Medicare Services (CMS) requirement of having Provider's Digital Contact Information added in the National Plan and Provider Enumeration System (NPPES).

- If Provider's EMR does not support the Direct Protocol, Provider will work with Molina's established interoperability partner to get an account established.

Your Role as a provider

As a Provider, your complete and accurate documentation in a Member's medical record and submitted Claims are critical to a Member's quality of care. We encourage Providers to code all diagnoses to the highest specificity as this will ensure Molina receives adequate resources to provide quality programs to you and our Members.

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

- Address clinical data elements (e.g., diabetic patient needs an eye exam or multiple comorbid conditions, SDOH (Social Determinants of Health) provided by Molina and reviewed with the Member.
- Be compliant with the CMS National Correct Coding Initiative.
- Use the correct ICD-10 code by coding the condition to the highest level of specificity.
- Only use diagnosis codes confirmed during a Provider visit with a Member. The visit may be face-to-face, or telehealth, depending on state or CMS requirements.
- Contain a treatment plan and progress notes.
- Contain the Member's name and date of service.
- Have the Provider's signature and credentials.

As a member of the enrollee's multidisciplinary treatment team, Specialty providers play a key role in working with Molina's care management team. Key roles may include:

- Guiding and coordinating care between specialty providers and the PCP
- Promoting primary care services
- Participating in Interdisciplinary Care Team meetings
- Assisting with transitions of care
- Promoting Molina programs such as disease management, healthy behaviors, and quality programs

Contact information

For questions about Molina's Risk Adjustment programs, please contact your Molina Provider Relations Representative.

11. Compliance

Fraud, waste and abuse

Introduction

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

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

Mission Statement

Our mission is to pay claims correctly the first time, and that mission begins with the understanding that we need to proactively detect fraud, waste, and abuse, correct it, and prevent it from reoccurring. Since not all fraud, waste, or abuse can be prevented, Molina employs processes that retrospectively address fraud, waste, or abuse that may have already occurred. Molina strives to detect, prevent, investigate, and report suspected health care fraud, waste, and abuse in order to reduce health care costs and 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 to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the claim;

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

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

Florida False Claims Act

Florida has also enacted a state False Claims Act (F.S. Title VI, §§ 68.081-68.089) in 2007 to allow for the recovery of state funds in addition to federal funds for false claims. The provisions of the Florida False Claims Act (FFCA) are similar, but not identical to, the provisions of the federal FCA. The FFCA provides for civil penalties of not less than $5,500 and not more than $11,000 per violation, for three times the damages to state government due to false claims, and for recovery of attorney's fees and court costs.

Deficit Reduction Act (DRA)

The DRA aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

As a contractor doing business with Molina, providers and their staff have the same obligation to report any actual or suspected violation or 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 a whistleblowers
- Administrative remedies for false Claims and statements

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 damage 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 will take steps to monitor Molina contracted providers to ensure compliance with the law. Health care entities (e.g., providers, facilities, delegates and/or vendors) to which Molina has paid $5 million or more in Medicaid funds during the previous federal fiscal year (October 1-September 30) will be required to submit a signed "Attestation of Compliance with the Deficit Reduction Act of 2005, Section 6032" to Molina.

Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))

Anti-Kickback Statute ("AKS") is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying for referrals is a crime. The statute covers the payers of kickbacks-those who offer or pay remuneration- as well as the recipients of kickbacks-those who solicit or receive remuneration.

Molina conducts all business in compliance with Federal and State Anti-Kickback Statutes (AKB) statutes and regulations and Federal and State marketing regulations. Providers are prohibited from engaging in any activities covered under this statute.

AKS statutes and regulations prohibit paying or receiving anything of value to induce or reward patient referrals or the generation of business involving any item or service payable by Federal and State health care programs. The phrase "anything of value" can mean cash, discounts, gifts, excessive compensation, contracts not at fair market value, etc. Examples of prohibited AKB actions include a health care Provider who is

compensated based on patient volume, or a Provider who offers remuneration to patients to influence them to use their services.

Under Molina's policies, Providers may not offer, solicit, provide, or receive items of value intended to induce referrals of Federal health care program business. Providers must not, directly or indirectly, make or offer items of value to any third party, to obtain, retain, or direct our business. This includes giving, favors, preferential hiring, or anything of value to any government official.

Marketing guidelines and requirements

Providers must conduct all marketing activities in accordance with the relevant contractual requirements and marketing statutes and regulations – both state and federal.

Under Molina's policies, Marketing means any communication, to a beneficiary who is not enrolled with Molina, that can reasonably be interpreted as intended to influence the beneficiary to enroll with Molina's Medicaid, Marketplace, or Medicare products. This also includes communications that can be interpreted to influence a beneficiary to not enroll in or to disenroll from another Health Plan's products.

Restricted marketing activities vary from state-to-state but generally relate to the types and form of communications that health plans, Providers and others can have with Members and prospective Members. Examples of such communications include those related to enrolling Members, Member outreach, and other types of communications.

Stark Statute

The Physicians Self-Referral Law (Stark Law) prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. The Stark law prohibits the submission or causing the submission of Claims in violation of the law's restrictions on referrals. "Designated health services" are identified in the Physician Self-Referral Law (42 U.S.C. § 1395nn)

Sarbanes-Oxley Act of 2002

The Sarbanes-Oxley Act requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a

corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Definitions

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

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

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

Examples of fraud, waste and abuse by a provider

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

- A Provider knowingly and willfully refers a Member to health care facilities in which or with which the Provider has a financial relationship. (Stark Law)
- Altering Claims and/or medical record documentation to get a higher level of reimbursement.
- Balance billing a Molina Member for Covered Services. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.
- Billing and providing services to Members that are not Medically Necessary.
- Billing for services, procedures and/or supplies that have not been rendered.
- Billing under an invalid place of service to receive or maximize reimbursement.

- Completing certificates of Medical Necessity for Members not personally and professionally known by the Provider.
- Concealing a Member's misuse of a Molina identification card.
- Failing to report a Member's forgery or alteration of a prescription or other medical document.
- False coding in order to receive or maximize reimbursement.
- Inappropriate billing of modifiers to receive or maximize reimbursement.
- Inappropriately billing of a procedure that does not match the diagnosis to receive or maximize reimbursement.
- Knowingly and willfully solicit or receiving payment of kickbacks or bribes in exchange for referring patients.
- Not following incident-to-billing guidelines to receive or maximize reimbursement.
- Overutilization
- Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges.
- Questionable prescribing practices.
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are Medically Necessary.
- Upcoding, which is when a Provider does not bill the correct code for the service rendered, and instead uses a code for a like services that costs more.
- Using the adjustment payment process to generate fraudulent payments.

Examples of fraud, waste and abuse by a Member

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

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

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 Florida Agency for Healthcare Administration's list of suspended and terminated providers at: http://apps.ahca.myflorida.com/dm_web
- 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 Services staff will request copies of relevant information from the appropriate government entity. Upon receiving this information, the documents are presented to the Credentialing Committee for review and potential action. The Credentialing staff will also present the list of physicians found on the Medicaid sanctions report to the Compliance Committee for review and potential oversight of action.

Review of provider Claims and Claims System

Molina Claims examiners are trained to recognize unusual billing practices, which are key in trying to identify fraud, waste, and abuse. If the Claims Examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the SIU through our Compliance Alertline/reporting repository.

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

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

Prepayment of fraud, waste and abuse detection activities

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

Molina has a pre-payment Claims auditing process that identifies frequent correct coding billing errors ensuring that Claims are coded appropriately according to State and Federal coding guidelines. Code edits relationships and edits are based on guidelines from specific State Medicaid Guidelines, Centers for Medicare & Medicaid Services (CMS), Federal CMS guidelines, AMA, and published specialty specific coding rules. Code Edit Rules are based on information received from the National Physician Fee Schedule Relative File (NPFS), the Medically Unlikely Edit (MUE) table, the National Correct Coding Initiative (NCCI) files, Local Coverage Determination/National Coverage Determination (LCD/NCD), and State-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

Additionally, Molina may, at the request of a state program or at its own discretion, subject a Provider to prepayment reviews whereupon Provider is required to submit supporting source documents that justify an amount charged. Where no supporting documents are provided, or insufficient information is provided to substantiate a charge, the Claim will be denied until the Provider can provide sufficient accurate support.

Post-payment recovery activities

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

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

The Provider will provide Molina, governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Molina, in Molina's sole discretion, necessary to determine compliance with the terms of the

Provider Agreement, including for the purpose of investigating potential fraud, waste and abuse. Documents and records must be readily accessible at the location where the Provider provides services to any Molina Members. Auditable documents and records include, but are not limited to, medical charts; patient charts; billing records; and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by Molina and without charge to Molina. In the event Molina identifies fraud, waste or abuse, Provider agrees to repay funds or Molina may seek recoupment.

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

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

Provider education

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

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

Specialty providers can take advantage of Molina's educational opportunities. Molina provides, at least quarterly, a Lunch and Learn series to providers to learn more about current treatments, community programs, and other system of care

enhancements. Molina also offers free continuing education units (CEUs) to providers via PsychHub, Molina's behavioral health training platform.

Reporting fraud, waste and abuse

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

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

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

Compliance Officer
Molina Healthcare of Florida
8300 NW 33rd St, Suite 400
Doral, Florida 33122
Confidential Fax: 866-440-8591

The following information should be included 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.

To report suspected fraud and/or abuse in Florida Medicaid, call the **Consumer Complaint Hotline toll- free at 1-888-419-3456** or complete a Medicaid Fraud and

Abuse Complaint Form, which is available online at https://apps.ahca.myflorida.com/mpi-complaintform/.

Suspected fraud and abuse may also be reported directly to the State at:

Department of Financial Services
Division of Insurance Fraud
200 East Gaines Street
Tallahassee, FL 32399-0318
Toll Free Phone: (877) 693-5236

Florida Attorney General
Fraud Hotline: (866) 966-7226

If you report suspected fraud and your report results in a fine, penalty or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (**toll-free (866) 966-7226 or (850) 414-3990**). The reward may be up to 25 percent of the amount recovered, or a maximum of $500,000 per case (Section 409.9203, Florida Statutes). You can talk to the Attorney General's Office about keeping your identity confidential and protected.

HIPAA requirements and information

Molina's commitment to patient privacy

Protecting the privacy of members' personal health information is a core responsibility that Molina Healthcare takes very seriously. Molina is committed to complying with all federal and state laws regarding the privacy and security of members' Protected Health Information (PHI).

Provider responsibilities

Molina expects that its contracted Providers/Practitioners will respect the privacy of Molina members and comply with all applicable laws and regulations regarding the privacy of patient and member PHI. Molina provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Molina uses and discloses their PHI and includes a summary of how Molina safeguards their PHI.

Telehealth/Telemedicine Providers: Telehealth transmissions are subject to HIPAA-related requirements outlined under State and Federal Law, including:

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

Providers must 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. Providers must ensure their staff receives periodic training regarding the confidentiality of Member information.

Applicable laws

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

1. Federal Laws and Regulations

    - HIPAA
    - The Health Information Technology for Economic and Clinical Health Act (HITECH)
    - 42 C.F.R. Part 2
    - Medicare and Medicaid laws
    - The Affordable Care Act

2. State Medical Privacy Laws and Regulations

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

Artificial intelligence

The Provider shall comply with all applicable state and federal laws and regulations related to artificial intelligence and the use of artificial intelligence tools (AI). Artificial Intelligence or AI means a machine-based system that can, with respect to a given set of human-defined objectives, input or prompt, as applicable, make predictions, recommendations, data sets, work product (whether or not eligible for copyright protection), or decisions influencing physical or virtual environments. The Provider is prohibited from using AI for any functions that result in a denial, delay, reduction, or

modification of covered services to Molina Members including, but not limited to utilization management, prior authorizations, complaints, appeals and grievances, and quality of care services, without review of the denial, delay, reduction or modification by a qualified clinician.

Notwithstanding the foregoing, the Provider shall give advance written notice to your Molina Contract Manager (for any AI used by the Provider that may impact the provision of covered services to Molina Members) that describes (i) Providers' use of the AI tool(s) and (ii) how the Provider oversees, monitors and evaluates the performance and legal compliance of such AI tool(s). If the use of AI is approved by Molina, the Provider further agrees to (i) allow Molina to audit Providers' AI use, as requested by Molina from time to time, and (ii) to cooperate with Molina with regard to any regulatory inquiries and investigations related to Providers' AI use related to the provision of covered services to Molina Members.

If you have additional questions, please contact your Molina Contract Manager.

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 healthcare operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI.

Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[1] Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services[2]".
2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of

[1] See Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule
[2] See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:

- Quality improvement
- Disease management;
- Case management and care coordination;
- Training Programs;
- Accreditation, licensing, and credentialing

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

Confidentiality of substance use disorder patient records

Federal Confidentiality of Substance Use Disorder Patients Records regulations apply to any entity or individual providing federally-assisted alcohol or drug abuse prevention treatment. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with substance use disorder treatment or programs are confidential and may

HIPAA protects substance use disorder information, the Federal Confidentiality of Substance Use Disorder Patients Records regulations are more restrictive than HIPAA and they do not allow disclosure without the Member's written consent except as set forth in 42 CFR Part 2.

Inadvertent disclosures of PHI

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

Written authorizations

Uses and disclosures of PHI not permitted or required under applicable law require valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable state law.

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:

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

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

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

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

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

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

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

HIPAA security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of Molina member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cybersecurity measures. Providers 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.

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

HIPAA transactions and code sets

Molina strongly supports the use of electronic transactions to streamline healthcare administrative activities. Molina Providers are encouraged to submit claims and other transactions to Molina 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 is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to Molina's website at MolinaHealthcare.com for additional information regarding HIPAA standard transactions.

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

Code sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions.

National Provider Identifier (NPI)

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

Additional requirements for delegated Providers

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

Reimbursement for Copies of PHI

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

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

Business Continuity Plan (BCP)

The Provider will have a documented Business Continuity Plan (BCP) to ensure continuation and recovery of services after a disruption occurs. The BCP will be updated at least annually and approved by the applicable designated representative.

The Provider Business Continuity Plan will include:

- Names and contact information for staff responsible for invoking and managing response and recovery
- Molina notification names and contact information
- Disaster declaration process
- Details of how the services will be recovered and restored
- Details of how the systems and applications supporting the services will be recovered and restored, including recovery of data

The Provider will notify Molina of a disruption to the services or activation of business continuity plans within two hours and will provide Molina with regular updates on the situation and actions taken to resolve the issue, until normal services have been resumed.

The Provider will ensure that its third parties needed to deliver the services have appropriate Business Continuity Plans in place to prevent significant disruption to the services.

The Provider will test the BCP at least annually and document the test results. Provider will make available to Molina, upon request, the results of the most recent test including lessons learned and remediation plans.

The Provider will participate in Molina annual tests upon notification and mutual agreement.

After disruption to services, once normal service has been resumed, the Provider will promptly complete a root cause analysis report and provide it to Molina.

Information security and cybersecurity

NOTE: This section (Information Security and Cybersecurity) is only applicable to providers who are delegated providers and have been delegated by Molina to perform a health plan function.

1. Definitions:

   (a) "Molina Information" means any information: (i) provided by Molina to Provider; (ii) accessed by Provider or available to Provider on Molina's Information Systems; or (iii) any information with respect to Molina or any of its consumers developed by Provider or other third parties in Provider's possession, including without limitation any Molina Nonpublic Information.

(b) "Cybersecurity Event" means any actual or reasonably suspected contamination, penetration, unauthorized access or acquisition or other breach of confidentiality, data integrity or security compromise of a network or server resulting in the known or reasonably suspected accidental, unauthorized or unlawful destruction, loss, alteration, use, disclosure of or access to Molina Information. For clarity, a Breach or Security Incident as these terms are defined under HIPAA constitute a Cybersecurity Event for the purpose of this section. Unsuccessful security incidents, which are activities such as pings and other broadcast attacks on Provider's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, do not constitute a Cybersecurity Event under this definition so long as no such incident results in or is reasonably suspected to have resulted in unauthorized access, use, acquisition or disclosure of Molina Information or sustained interruption of service obligations to Molina.

(c) "HIPAA" means the Health Insurance Portability and Accountability Act, as may be amended from time to time.

(d) "HITECH" means the Health Information Technology for Economic and Clinical Health Act, as may be amended from time to time.

(e) "Industry Standards" mean as applicable, codes, guidance (from regulatory and advisory bodies, whether mandatory or not), international and national standards, relating to security of network and information systems and security breach and incident reporting requirements, all as amended or updated from time to time and including but not limited to the current standards and benchmarks set forth and maintained by the following, in accordance with the latest revisions and/or amendments:

i. HIPAA and HITECH
ii. HITRUST Common Security Framework
iii. Center for Internet Security
iv. National Institute for Standards and Technology ("NIST") Special Publications 800.53 Rev.5 and 800.171 Rev. 1 or as currently revised
v. Federal Information Security Management Act ("FISMA")
vi. ISO/ IEC 27001
vii. Federal Risk and Authorization Management Program ("FedRamp")
viii. NIST Special Publication 800-34 Revision 1 – "Contingency Planning Guide for Federal Information Systems."

ix. International Organization for Standardization (ISO) 22301 – "Societal security – Business continuity management systems – Requirements."

(f) "Information Systems" means all computer hardware, databases and data storage systems, computer, data, database and communications networks (other than the Internet), cloud platform, architecture interfaces and firewalls (whether for data, voice, video or other media access, transmission or reception) and other apparatus used to create, store, transmit, exchange or receive information in any form.

(g) "Multi-Factor Authentication" means authentication through verification of at least two of the following types of authentication factors: (1) knowledge factors, such as a password; (2) possession factors, such as a token or text message on a mobile phone; (3) inherence factors, such as a biometric characteristic; or (4) any other industry standard and commercially accepted authentication factors.

(h) "Nonpublic Information" includes:

i. Molina's proprietary and/or confidential information;

ii. Personally Identifiable Information as defined under applicable state data security laws, including, without, limitation, "nonpublic personal information," "personal data," "personally identifiable information," "personal information" or any other similar term as defined pursuant to any applicable law; and

iii. Protected Health Information as defined under HIPAA and HITECH.

2. Information Security and Cybersecurity Measures. Provider shall implement and at all times maintain, appropriate administrative, technical and physical measures to protect and secure the Information Systems, as well as Nonpublic Information stored thereon and Molina Information that are accessible to or held by, Provider. Such measures shall conform to generally recognized industry standards and best practices and shall comply with applicable privacy and data security laws, including implementing and maintaining administrative, technical and physical safeguards pursuant to HIPAA, HITECH and other applicable U.S. federal, state and local laws.

(a) Policies, Procedures and Practices. Provider must have policies, procedures and practices that address its information security and cybersecurity measures, safeguards and standards, including as applicable, a written information security program, which Molina shall be

permitted to audit via written request and which shall include at least the following:

i. Access Controls. Access controls, including Multi-Factor Authentication, to limit access to the Information Systems and Molina Information accessible to or held by Provider.

ii. Encryption. Use of encryption to protect Molina Information, in transit and at rest, accessible to or held by Provider.

iii. Security. Safeguarding the security of the Information Systems and Molina Information accessible to or held by Provider, which shall include hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, regular (three or more annually) third party vulnerability assessments, physical security controls and personnel training programs that include phishing recognition and proper data management hygiene.

iv. Software Maintenance. Software maintenance, support, updates, upgrades, third party software components and bug fixes such that the software is and remains, secure from vulnerabilities in accordance with the applicable Industry Standards.

(b) Technical Standards. Provider shall comply with the following requirements and technical standards related to network and data security:

i. Network Security. Network security shall conform to generally recognized industry standards and best practices. Generally recognized industry standards include, but are not limited to, the applicable Industry Standards.

ii. Cloud Services Security: If Provider employs cloud technologies, including infrastructure as a service (IaaS), software as a service (SaaS) or platform as a service (PaaS), for any services, Provider shall adopt a "zero-trust architecture" satisfying the requirements described in NIST 800-207 (or any successor cybersecurity framework thereof).

iii. Data Storage. Provider agrees that any and all Molina Information will be stored, processed and maintained solely on designated target servers or cloud resources. No Molina Information at any time will be processed on or transferred to any portable or laptop computing device or any portable storage medium, unless that device or storage medium is in use as part of the Provider's

designated backup and recovery processes and is encrypted in accordance with the requirements set forth herein.

iv. Data Encryption. Provider agrees to store all Molina Information as part of its designated backup and recovery processes in encrypted form, using a commercially supported encryption solution. Provider further agrees that any and all Molina Information, stored on any portable or laptop computing device or any portable storage medium be likewise encrypted. Encryption solutions will be deployed with no less than a 128-bit key for symmetric encryption, a 1024 (or larger) bit key length for asymmetric encryption and the Federal Information Processing Standard Publication 140-2 ("FIPS PUB 140-2").

v. Data Transmission. Provider agrees that any and all electronic transmission or exchange of system and application data with Molina and/or any other parties expressly designated by Molina shall take place via secure means (using HTTPS or SFTP or equivalent) and solely in accordance with FIPS PUB 140-2 and the Data Re-Use requirements set forth herein.

vi. Data Re-Use. Provider agrees that any and all Molina Information exchanged shall be used expressly and solely for the purposes enumerated in the Provider Agreement with Molina and this section. Data shall not be distributed, repurposed or shared across other applications, environments or business units of Provider. Provider further agrees that no Molina Information or data of any kind shall be transmitted, exchanged or otherwise passed to other affiliates, contractors or interested parties, except on a case-by-case basis as specifically agreed to in advance and in writing by Molina.

3. Business Continuity ("BC") and Disaster Recovery ("DR"). Provider shall have documented procedures in place to ensure continuity of Provider's business operations, including disaster recovery, in the event of an incident that has the potential to impact, degrade or disrupt Provider's delivery of services to Molina.

(a) Resilience Questionnaire. Provider shall complete a questionnaire provided by Molina to establish Provider's resilience capabilities.

(b) BC/DR Plan.

i. Provider's procedures addressing continuity of business operations, including disaster recovery, shall be collected and/or summarized in a documented BC and DR plan or plans in written format ("BC/DR Plan"). The BC/DR Plan shall identify the service level agreement(s)

established between Provider and Molina. The BC/DR Plan shall include the following:

a) Notification, escalation and declaration procedures.
b) Roles, responsibilities and contact lists.
c) All Information Systems that support services provided to Molina.
d) Detailed recovery procedures in the event of the loss of people, processes, technology and/or third-parties or any combination thereof providing services to Molina.
e) Recovery procedures in connection with a Cybersecurity Event, including ransomware.
f) Detailed list of resources to recover services to Molina including but not limited to: applications, systems, vital records, locations, personnel, vendors and other dependencies.
g) Detailed procedures to restore services from a Cybersecurity Event including ransomware.
h) Documented risk assessment which shall address and evaluate the probability and impact of risks to the organization and services provided to Molina. Such risk assessment shall evaluate natural, man-made, political and cybersecurity incidents.

ii. To the extent that Molina Information is held by Provider, Provider shall maintain backups of such Molina Information that are adequately protected from unauthorized alterations or destruction consistent with applicable Industry Standards.
iii. Provider shall develop information technology disaster recovery or systems contingency plans consistent with applicable Industry Standards and in accordance with all applicable laws.

(c) Notification. Provider shall notify Molina's Chief Information Security Officer by telephone and email (provided herein) as promptly as possible, but not to exceed 24 hours, of either of the following:

i. Provider's discovery of any potentially disruptive incident that may impact or interfere with the delivery of services to Molina or that detrimentally affects Provider's Information Systems or Molina's Information.
ii. Provider's activation of business continuity plans. Provider shall provide Molina with regular updates by telephone or email (provided

herein) on the situation and actions taken to resolve the issue, until normal services have been resumed.

(d) BC and DR Testing. For services provided to Molina, Provider shall exercise its BC/DR Plan at least once each calendar year. Provider shall exercise its cybersecurity recovery procedures at least once each calendar year. At the conclusion of the exercise, Provider shall provide Molina a written report in electronic format upon request. At a minimum, the written report shall include the date of the test(s), objectives, participants, a description of activities performed, results of the activities, corrective actions identified and modifications to plans based on results of the exercise(s).

4. Cybersecurity Events.

(a) Provider agrees to comply with all applicable data protection and privacy laws and regulations. Provider will implement best practices for incident management to identify, contain, respond to and resolve Cybersecurity Events.

(b) In the event of a Cybersecurity Event that threatens or affects Molina's Information Systems (in connection with Provider having access to such Information Systems); Provider's Information Systems; or Molina Information accessible to or held by Provider, Provider shall notify Molina's Chief Information Security Officer of such event by telephone and email as provided below (with follow-up notice by mail) as promptly as possible, but in no event later than 24 hours from Provider's discovery of the Cybersecurity Event.

i. In the event that Provider makes a ransom or extortion payment in connection with a Cybersecurity Event that involves or may involve Molina Information, Provider shall notify Molina's Chief Information Security Officer (by telephone and email, with follow-up notice by mail) within 24 hours following such payment.

ii. Within 15 days of such a ransom payment that involves or may involve Molina Information, Provider shall provide a written description of the reasons for which the payment was made, a description of alternatives to payment considered, a description of due diligence undertaken to find alternatives to payment and evidence of all due diligence and sanctions checks performed in compliance with applicable rules and regulations, including those of the Office of Foreign Assets Control.

(c) Notification to Molina's Chief Information Security Officer shall be provided to:

Molina Chief Information Security Officer
Telephone: (844) 821-1942
Email: CyberIncidentReporting@Molinahealthcare.com

Molina Chief Information Security Officer
Molina Healthcare, Inc.
200 Oceangate Blvd., Suite 100
Long Beach, CA 90802

(d) In the event of a Cybersecurity Event, Provider will, at Molina's request, (i) fully cooperate with any investigation concerning the Cybersecurity Event by Molina, (ii) fully cooperate with Molina to comply with applicable law concerning the Cybersecurity Event, including any notification to consumers and (iii) be liable for any expenses associated with the Cybersecurity Event including without limitation: (a) the cost of any required legal compliance (e.g., notices required by applicable law) and (b) the cost of providing two (2) years of credit monitoring services or other assistance to affected consumers. In no event will Provider serve any notice of or otherwise publicize a Cybersecurity Event involving Molina Information without the prior written consent of Molina

(e) Following notification of a Cybersecurity Event, Provider must promptly provide Molina any documentation requested by Molina to complete an investigation, or, upon request by Molina, complete an investigation pursuant to the following requirements:

i. make a determination as to whether a Cybersecurity Event occurred;
ii. assess the nature and scope of the Cybersecurity Event;
iii. identify Molina's Information that may have been involved in the Cybersecurity Event; and
iv. perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release or use of Molina Information.

(f) Provider must provide Molina the following required information regarding a Cybersecurity Event in electronic form. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Molina concerning the Cybersecurity Event. The

information provided to Molina must include at least the following, to the extent known:

i. the date of the Cybersecurity Event;
ii. a description of how the information was exposed, lost, stolen or breached;
iii. how the Cybersecurity Event was discovered;
iv. whether any lost, stolen or breached information has been recovered and if so, how this was done;
v. the identity of the source of the Cybersecurity Event;
vi. whether Provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and, if so, when such notification was provided;
vii. a description of the specific types of information accessed or acquired without authorization, which means particular data elements including, for example, types of medical information, types of financial information or types of information allowing identification of the consumer;
viii. the period during which the Information System was compromised by the Cybersecurity Event;
ix. the number of total consumers in each state affected by the Cybersecurity Event;
x. the results of any internal review identifying a lapse in either automated controls or internal procedures or confirming that all automated controls or internal procedures were followed;
xi. a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;
xii. a copy of Provider's privacy policy and a statement outlining the steps Provider will take to investigate and if requested by Molina, the steps that Provider will take to notify consumers affected by the Cybersecurity Event; and
xiii. the name of a contact person who is familiar with the Cybersecurity Event and authorized to act on behalf of Provider.

(g) Provider shall maintain records concerning all Cybersecurity Events for a period of at least five (5) years from the date of the Cybersecurity Event or such longer period as required by applicable laws and produce those records upon Molina's request.

5. Right to Conduct Assessments; Provider Warranty. Provider agrees to fully cooperate with any security risk assessments performed by Molina and/or any

designated representative or vendor of Molina. Provider agrees to promptly provide accurate and complete information with respect to such security risk assessments. If Molina performs a due diligence/security risk assessment of Provider, Provider (i) warrants that the services provided pursuant to the Provider Agreement with Molina will be in compliance with generally recognized industry standards and as provided in Provider's response to Molina's due diligence/security risk assessment questionnaire; (ii) agrees to inform Molina promptly of any material variation in operations from what was provided in Provider's response to Molina's due diligence/security risk assessment; and (iii) agrees that any material deficiency in operations from those as described in the Provider's response to Molina's due diligence/security risk assessment questionnaire may be deemed a material breach of the Provider Agreement with Molina.

6. Other Provisions. Provider acknowledges that there may be other information security and data protection requirements applicable to Provider in the performance of services which may be addressed in an agreement between Molina and Provider, but are not contained in this section.

7. Conflicting Provisions. In the event of any conflict between the provisions of this section and any other agreement between Molina and Provider, the stricter of the conflicting provisions will control.

12 Claims and compensation

Payer ID	51062
Availity portal	provider.MolinaHealthcare.com
Clean Claim Timely Filling	six months after the discharge for inpatient services or the Date of Service for outpatient services

Electronic Claim Submission

Molina strongly encourages participating Providers to submit Claims electronically, including secondary claims. Electronic Claims submission provides significant benefits to the Provider, including:

- Helps to reduce operation costs associated with paper claims (printing, postage, etc.)
- Increases accuracy of data and efficient information delivery
- Reduces Claim delays since errors can be corrected and resubmitted electronically

- Eliminates mailing time and Claims reach Molina faster

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the Availity portal
- Submit Claims to Molina via your regular EDI clearinghouse using Payer ID 51062

Availity portal

The Availity portal is a no cost online platform that offers several Claims processing features:

- Submit Professional (CMS1500) and Institutional (CMS-1450) {UB04} Claims with attached files.
- Correct/void Claims.
- Add attachments to previously submitted Claims
- Check Claims status
- View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
- Create and manage Claim templates
- Create and submit a Claim appeal with attached files

Clearinghouse

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

If you do not have a clearinghouse, Molina offers additional electronic Claim submissions options as shown by logging on to the Availity portal.

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

When your Claims are filed via a clearinghouse:

- You should receive a 999 acknowledgment from your clearinghouse
- You should also receive 277CA response file with initial status of the Claims from your clearinghouse
- You should refer to the Molina Companion Guide for information on the response format and messages

- You should contact your local clearinghouse representative if you experience any problems with your transmission

EDI Claim submission issues

Providers who are experiencing EDI submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider should contact their Molina Provider Relations representative for additional support.

Timely Claim filing

Providers shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina and shall include any and all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by the Provider to Molina within six (6) months after the discharge for inpatient services or the date of service for outpatient services. If Molina is not the primary payer under coordination of benefits or third-party liability, the Provider must submit Claims to Molina within ninety (90) days after final determination by the primary payer. Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Claim submission

Participating Providers are required to submit Claims to Molina with appropriate documentation. Providers must follow the appropriate State and CMS Provider billing guidelines. Providers must utilize electronic billing though a clearinghouse or Molina's Availity portal, use current HIPAA compliant ANSI X12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims). For Members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim Submission instructions on the Member's Molina ID card.

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

To verify the status of your claims, please visit the Availity portal or call our Provider Claims Representatives at the numbers listed below.

Phone: (855) 322-4076
Email: MFLProviderServices@MolinaHealthcare.com
TTY: (800) 955-8771 or 711 (English); (800) 955-8773 (Spanish)
Availity portal: provider.MolinaHealthcare.com

National Provider Identifier (NPI)

A valid NPI is required on all Claim submissions. Providers must report any changes in their NPI or subparts to Molina as soon as possible, not to exceed 30 calendar days from the change. Molina supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. Molina may validate the NPI submitted in a Claim transaction is a valid NPI and is recognized as part of the NPPES data.

Required elements

Electronic submitters should use the Implementation Guide and Molina Companion Guide for format and code set information when submitting or receiving files directly with Molina. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the Molina website under EDI>Companion Guides for regularly updated information regarding Molina's companion guide requirements. Be sure to choose the appropriate State from the drop-down list on the top of the page. In addition to the Molina Companion Guide, it is also necessary to use the State Health Plan specific companion guides, which are also available on our Molina website for your convenience (remember to choose the appropriate state from the drop-down list).

Electronic Claim submissions will adhere to specifications for submitting medical Claim data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for compliance with Strategic National Implementation Process (SNIP) levels 1-5.

The following information must be included on every claim, paper or electronic:

- Member name, date of birth and Molina Member ID number.
- Member's gender.
- Member's address.
- Date(s) of service.
- Valid International Classification of Diseases diagnosis and procedure codes.
- Valid revenue, CPT or HCPCS for services or items provided.

- Valid Diagnosis Pointers.
- Total billed charges for service provided.
- Place and type of service code.
- Days or units as applicable.
- Provider tax identification.
- National Provider Identifier (NPI) or Atypical Provider Identifier (API).
- Rendering Provider information when different than billing.
- Provider name and billing address.
- National Drug Code (NDC), unit of measure and quantity for medical injectables
- Place of service and type (for facilities).
- Disclosure of any other health benefit plans.
- E-signature.
- Service Facility Location.
- Any other state required information.

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

Provider and Member data will be verified for accuracy and active status. Be sure to validate this data in advance of Claims submission. This validation will apply to all Provider data submitted and also applies to atypical and out-of-state Providers.

EDI (Clearinghouse) Submission

Corrected Claim information submitted via EDI submission are required to follow electronic Claim standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 5. The 837 Claim format allows you to submit changes to Claims that were not included in the original adjudication.

The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called "Claim frequency codes." Using the appropriate code, you can indicate that the Claim is an adjustment of a previously submitted finalized Claim. Use the below frequency codes for Claims that were previously adjudicated.

Claim Frequency Code	Description	Action
7	Use to replace an entire Claim.	Molina will adjust the original Claim. The corrections submitted represent a

		complete replacement of the previously processed Claim.
8	Use to eliminate a previously submitted Claim.	Molina will void the original Claim from records based on request.

When submitting Claims noted with Claim frequency code 7 or 8, the original Claim number must be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The original Claim number can be obtained from the 835 Electronic Remittance Advice (ERA). Without the original Claim number, adjustment requests will generate a compliance error, and the Claim will be rejected.

Claim corrections submitted without the appropriate frequency code will be denied as a duplicate and the original Claim number will not be adjusted.

Paper Claim submission

Participating Providers should submit Claims electronically. If electronic Claim submission is not possible, all hard copy (CMS-1500, CMS-1450 {UB-04}) claims must be submitted by mail to the address listed below.

Molina Healthcare of Florida, Inc.
PO Box 22812
Long Beach, CA 90801

When submitting paper Claims:

- Paper Claim submissions are not considered to be "accepted" until received at the appropriate Claims PO Box; Claims received outside of the designated PO Box will be returned for appropriate submission.
- Paper Claims are **required** to be submitted on original red and white CMS-1500 and CMS-1450 (UB-04) Claim forms.
- Paper Claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms, and any altering to include Claims with handwriting.
- Claims must be typed with either 10- or 12-point Times New Roman font, using black ink.
- Link to paper Claims submission guidance from CMS: cms.gov/Medicare/Billing/ElectronicBillingEDITrans/1500

To verify the status of your claims, please visit the Availity portal or call our Provider Claims Representatives at the numbers listed below.

- Phone: (855) 322-4076
- Email: MFLProviderServices@MolinaHealthcare.com
- TTY: (800) 955-8771 or 711 (English); (800) 955-8773 (Spanish)
- Availity portal: provider.MolinaHealthcare.com

Corrected Claim process

Providers may correct any necessary field of the CMS-1500 and CMS-1450 (UB-04) forms.
Molina strongly encourages participating Providers to submit Corrected Claims electronically via EDI or the Availity portal.

All Corrected Claims:

- Must be free of handwritten or stamped verbiage (paper Claims).
- Must be submitted on a standard red and white CMS-1450 (UB-04) or CMS-1500 Claim form (paper Claims).
- Original Claim number must be inserted in field 64 of the CMS-1450 (UB-04) or field 22 of the CMS-1500 of the paper Claim, or the applicable 837 transaction loop for submitting corrected claims electronically.
- The appropriate frequency code/resubmission code must also be billed in field 4 of the CMS-1450 (UB-04) and 22 of the CMS-1500.

Corrected Claims must be sent within six months of Date of Service or most recent adjudicated date of the Claim.

Corrected Claim submission options:

- Submit Corrected Claims directly to Molina via the Availity portal.
- Submit corrected Claims to Molina via your regular EDI clearinghouse.

Coordination of benefits (COB) and third-party liability (TPL)

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured, or self-funded, or commercial carrier, automobile insurance, and worker's compensation) or program that is or may be liable to pay all or part of the health care expenses of the Member.

Medicaid is always the payer of last resort and Providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Molina Members. If third party liability can be established, Providers must bill the primary payer and submit a primary explanation of benefits (EOB) to Molina for secondary Claim processing. In the event that coordination of benefits occurs, Provider shall be reimbursed based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including EOB and other required documents. Molina will pay claims for prenatal care and preventive pediatric care (EPSDT) and then seek reimbursement from third parties. If services and payment have been rendered prior to establishing third party liability, an overpayment notification letter will be sent to the Provider requesting a refund including third party policy information required for billing.

Subrogation - Molina retains the right to recover benefits paid for a Member's health care services when a third party is responsible for the Member's injury or illness to the extent permitted under State and Federal law and the Member's benefit plan.

If third party liability is suspected or known, please refer pertinent case information to Molina's vendor at:

Optum: submitreferrals@optum.com

Hospital-acquired conditions (HAC) and present on admission (POA) program

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

The following is a list of CMS hospital-acquired conditions. Effective October 1, 2008, CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission (POA):

1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers

5. Falls and Trauma
    a) Fractures
    b) Dislocations
    c) Intracranial Injuries
    d) Crushing Injuries
    e) Burn
    f) Other Injuries
6. Manifestations of Poor Glycemic Control
    a) Hypoglycemic Coma
    b) Diabetic Ketoacidosis
    c) Non-Ketotic Hyperosmolar Coma
    d) Secondary Diabetes with Ketoacidosis
    e) Secondary Diabetes with Hyperosmolarity
7. Catheter-Associated Urinary Tract Infection (UTI)
8. Vascular Catheter-Associated Infection
9. Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
10. Surgical Site Infection Following Certain Orthopedic Procedures:
    a) Spine
    b) Neck
    c) Shoulder
    d) Elbow
11. Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
    a) Laparoscopic Gastric Restrictive Surgery
    b) Laparoscopic Gastric Bypass
    c) Gastroenterostomy
12. Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
13. Iatrogenic Pneumothorax with Venous Catheterization
14. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
    a) Total Knee Replacement
    b) Hip Replacement

What this means to Providers:

- Acute IPPS Hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing; and
- No additional payment will be made on IPPS hospital claims for conditions that are acquired during the patient's hospitalization.

If you would like to find out more information regarding the Medicare HAC/POA program, including billing requirements, the following CMS site provides further information: www.cms.hhs.gov/HospitalAcqCond/.

Molina coding policies and payment policies

Frequently requested information on Molina's Coding Policies and Payment Policies is available on the Payment Integrity Policy (molinahealthcare.com) website under the Policies tab. Questions can be directed to your Provider Services representative.

Reimbursement guidance and payment guidelines

Providers are responsible for the submission of accurate Claims. Molina requires coding of both diagnoses and procedures for all Claims as follows:

For diagnoses, the required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)

For procedures:

Professional and outpatient Claims require the Healthcare Common Procedure Coding System, Current Procedural Terminology Level 1 (CPT codes), Level 2 and 3 (HCPCS codes)

Inpatient hospital Claims require International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)

Furthermore, Molina requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

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

- Manuals and Relative Value Unit (RVU) files published by the Centers for Medicare & Medicaid Services (CMS), including:
  - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUE). In the event a State benefit limit is more stringent/restrictive than a Federal MUE, Molina will apply the State benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a Federal MUE or State benefit limit the professional organization standard may be used.
  - In the absence of State guidance, Medicare National Coverage Determinations (NCD).

  - In the absence of State guidance, Medicare Local Coverage Determinations (LCD).
  - CMS Physician Fee Schedule RVU indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics. · State-specific Claims reimbursement guidance.
- State-specific Claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than State and Federal guidelines.
- Molina policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Molina.

Telehealth Claims and billing

Providers must follow CMS guidelines as well as State-level requirements.

All telehealth Claims for Molina Members must be submitted to Molina with correct codes for the plan type in accordance with applicable billing guidelines.
For guidance, please refer to the resources located below:

State	Link 1	Link 2
FL	FL Medicaid Adopted Rules-General Polices-Telemedicine-59G-1.057	FL Medicaid Florida Medicaid-Health Care Alert March 18, 2020-Provider Type(s): All Medicaid Telemedicine Guidance for Medical and Behavioral Health Providers

National Correct Cording Initiative (NCCI)

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

NCCI Procedure to Procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures

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

General Coding Requirements

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

CPT and HCPCS codes

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the AMA CPT and HCPCS codebooks. In order to ensure proper and timely reimbursement, codes must be effective on the date of service (DOS) for which the procedure or service was rendered and not the date of submission.

Modifiers

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

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

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

ICD-10-CM/PCS codes

Molina utilizes International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and International Classification of Diseases 10th Revision, Procedure Coding System (ICD-10-PCS) billing rules and will deny Claims that do not meet Molina's ICD-10 Claim Submission Guidelines. To ensure proper and timely reimbursement, codes must be effective on the dates of service (DOS) for which the procedure or service was rendered and not the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

Place of Service (POS) codes

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

Type of bill

Type of bill is a four-digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC) Official CMS-1450 (UB-04) Data Specifications Manual.

Revenue codes

Revenue codes are four-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the NUBC's Official CMS-1450 (UB-04) Data Specifications Manual.

Diagnosis related group (DRG)

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

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

National drug code (NDC)

The National Drug Code Number (NDC) must be reported on all professional and outpatient claims when submitted on the CMS-1500 claim form, CMS-1450 (UB-04) or its electronic equivalent.

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

Patient Responsibility

What is Patient Responsibility?

Patient Responsibility is the cost of Medicaid Long-Term Care (LTC) services not paid for by the Medicaid program, for which the member is responsible. Patient responsibility is the amount member must contribute toward the cost of their care. The amount of patient responsibility is determined by the Department of Children & Families (DCF) and is based on income and choice of residence.

Medicaid must reduce payments for Home and Community-Based Services (HCBS) provided under the Statewide Medicaid Managed Care (SMMC) LTC waiver, by the amount of the member's patient responsibility, in compliance with Title 42, Section 435.726, Code of Federal Regulations; and Section 2404 of the Affordable Care Act. This includes residents in Assisted Living Facilities (ALFs), Nursing Facilities (SNFs), Hospices, and Adult-Family Care Homes (AFCHs).

DCF calculates and determines member patient responsibility. Members are responsible for the patient responsibility determined by DCF when residing in a participating residential facility. **Providers are responsible for collecting patient responsibility *and* room and board for Molina members.** Molina will reduce payments made to SNF's, Hospices, ALF's and AFCH's by the amount of patient responsibility determined by DCF.

Submitting documentation to DCF

The facility or member must provide DCF with documentation of the amount of the facility's basic room and board charges per month. The amount of the facility's basic room and board charges covers three meals per day and a semi-private room. The amount of the facility's basic room and board charges does not cover any goods and services beyond three (3) meals per day and a semi-private room.

The member may submit the facility's documentation to DCF by uploading files online to their MyACCESS Account or, they, or the facility may submit documentation to DCF by either:

- Faxing the documentation to: (866)-886-4342; or
- Mailing the documentation to:

  ACCESS Central Mail Center
  PO Box 1770
  Ocala, FL 34478-1770

Uncovered medical expense deduction

An Uncovered Medical Expense Deduction (UMED) may occur when the Molina member incurs a charge for a medically necessary service that is not covered by a third-party payer, Medicare, MMA, or LTC. Examples of qualified UMEDs are a premium, deductible, or coinsurance charge for health insurance coverage or medical expenses that are approved by DCF.

DCF may change the monthly amount of patient responsibility and determine to increase the amount of the member's patient responsibility due to an increase in the member's income or decrease the amount of patient responsibility due to a DCF approved UMED. DCF will notify members when there is a change in the monthly amount of patient responsibility by mailing a Notice of Case Action (NOCA) to the member.

Members must notify DCF within ten (10) days of receiving a bill/receipt of what medical expenses (paid or unpaid) they must pay. The member may submit the proof of medical expenses to DCF by uploading files online to their MyACCESS Account, by either:

- Faxing the documentation to: (866)-886-4342; or
- Mailing the documentation to:

  ACCESS Central Mail Center
  PO Box 1770
  Ocala, FL 34478-1770

Verifying member patient responsibility

Providers may view member patient responsibility information via the 'DCF Provider View' option in the Florida Medicaid Secure Provider Web Portal found at https://sso.flmmis.com/adfs/ls/?wa=wsignin1.0&wtrealm=https%3a%2f%2fsso2.flmmis.com%2fadfs%2fls%2fid&wctx=d19e0a5d-f160-413b-936d-7f68bde377d4&wct=2016-10-10T18%3a52%3a50Z&whr=https%3a%2f%2fsso.flmmis.com%2fadfs%2fls%2fid

Providers may also contact DCF if there are any questions about the information found on the DCF Availity portal or if they are unable to obtain needed information by contacting the DCF Customer Call Center at (866)-762-2237.

Coding sources

Definitions

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

- Category I Code – Procedures/Services
- Category II Code – Performance Measurement
- Category III Code – Emerging Technology

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

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

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

Claim auditing

Molina shall use established industry Claims adjudication and/or clinical practices, State, and Federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding, and payment.

Provider acknowledges Molina's right to conduct post-payment billing audits. Provider shall cooperate with Molina's audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon Molina's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in overpayment.

In reviewing medical records for a procedure, Molina may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims Molina paid in error. The estimated proportion, or error rate, may be projected across all Claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal Claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor assisted. Molina asks that you provide Molina, or Molina's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If Molina's Special Investigations Unit suspects that there is fraudulent or abusive activity, we may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

Timely Claim processing

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

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

Electronic Claim payment

Participating Providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, provides searchable ERAs, and Providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at MolinaHealthcare.com or by contacting our Provider Services Department.

Overpayments and incorrect payments refund requests

Molina requires network Providers to report to Molina when they have received an overpayment and to return the overpayment to Molina within 60 calendar days after the date on which the overpayment was identified and notify Molina in writing of the reason for the overpayment.

If, as a result of retroactive review of coverage decisions or payment levels, Molina determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a claim for such Overpayment. Providers will receive an overpayment request letter if the overpayment is identified in accordance with State and CMS guidelines. Providers will be given the option to either:

1. Submit a refund to satisfy overpayment,
2. Submit request to offset from future claim payments, or
3. Dispute overpayment findings.

A copy of the overpayment request letter and details are available in the Availity portal. In the Overpayment Application section, Providers can make an inquiry, contest

an overpayment with supporting documentation, resolve an overpayment or check status. This is Molina's preferred method of communication.

Instructions will be provided on the overpayment notice and overpayments will be adjusted and reflected in your remittance advice. The letter timeframes are Molina standards and may vary depending on applicable state guidelines and contractual terms.

Overpayments related to TPL/COB will contain primary insurer information necessary for rebilling including the policy number, effective date, term date, and subscriber information. For members with Commercial COB, Molina will provide notice within 270 days from the claim's paid date if the primary insurer is a Commercial plan. For members with Medicare COB Molina will provide notice within 540 days from the claim's paid date if the primary insurer is a Medicare plan. A provider may resubmit the claim with an attached primary EOB after submission to the primary payer for payment. Molina will adjudicate the claim and pay or deny the claim in accordance with claim processing guidelines.

A Provider shall pay a Claim for an Overpayment made by Molina which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider.

If a provider does not repay or dispute the overpaid amount within the timeframe allowed, Molina may offset the overpayment amount(s) against future payments made to the provider.

Payment of a Claim for Overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to Molina, or the date that the Provider receives a payment from Molina that reduces or deducts the Overpayment.

Refund Requests may be sent to:

Molina Healthcare of Florida, Inc.
Cost Recovery Department
PO Box 741037
Atlanta, GA 30374-1037

Claim disputes/reconsiderations/appeals

Information on Claim Disputes/Reconsiderations/Appeals is located in the Complaints, Grievances and Appeals section of this Provider Manual.

Balance billing

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

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. Balance billing a Member for covered services is prohibited, except for the Member's applicable copayment, coinsurance and deductible amounts.

Fraud, waste and abuse

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

Encounter data

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

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

Molina has a comprehensive automated and integrated Encounter data system capable of supporting all 837 file formats and proprietary formats if needed.

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

Molina created 837P, 837I, and 837D Companion Guides with the specific submission requirements available to Providers.

When Encounters are filed electronically Providers should receive two types of responses:

- First, Molina will provide a 999 acknowledgement of the transmission.
- Second, Molina will provide a 277CA response file for each transaction.

13. Complaints, grievance and appeals process

Molina Members or Member's personal representatives have the right to file a complaint, grievance and submit an appeal through a formal process. This section addresses the identification, review and resolution of Member grievances and appeals. Below are Molina's Member Grievance and Appeals Process.

Member complaints, grievance & appeals process

If a Member is unhappy with the service from Molina or providers contracted with Molina, they may file a complaint or a formal grievance by contacting Member Services toll-free at (866) 472-4585, Monday – Friday 8 a.m. – 7 p.m. They can also write to us at:

Molina Healthcare of Florida
Appeal and Grievance Unit
P.O Box 36030
Louisville, KY 40233-6030

Members may also send their written grievance via fax to (877) 508-5748 or submit via email at MFLGrievanceandAppeals@MolinaHealthcare.com.

Members are notified of their grievance and appeal rights and the different levels of grievances and appeals through various general communications including, but not limited to, the Member handbook, Member newsletters and Molina's website: MolinaHealthcare.com. Members are notified of these rights upon enrollment, and annually thereafter. Members may identify an individual, including an attorney or provider, to serve as a personal representative to act on their behalf at any stage during the grievance and appeals process. If under applicable law, a person has authority to act on behalf of a Member in making decisions related to health care or is a legal representative of the Member, Molina will treat such person as a personal representative.

If the Member/Provider registers an informal complaint, Molina will attempt to resolve the complaint within 24 hours. If the complaint cannot be resolved, it will be treated as a formal grievance. A member may file a grievance orally or in writing at any time.

A member, authorized representative, or legal representative of the estate may file a plan appeal orally or in writing within 60 calendar days from the date on the Notice of Adverse Benefit Determination.

Members are given reasonable assistance in completing forms and taking other procedural steps, including translation services for Members with limited English proficiency or other limitations, e.g., hearing impaired, requiring communication support.

All grievances whether oral or in writing, and Appeals (oral, followed by written confirmation within five days of) are documented by the Member Services Department in all appropriate systems, and written acknowledgement is sent to all parties.

Any issues related to a clinical denial and/or appeal of a coverage decision, is referred to the Utilization Management Department to review the medical necessity aspects of the request.

A person not involved in the previous decision-making process reviews the grievance or appeal to determine the resolution. In appeals involving denial of clinical services, health care professionals with appropriate expertise conduct the review. A Medical Director of the same or similar specialty who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination will review the appeal and make the determination.

All grievance and appeal requests concerning admissions, continued stay, immediate care issues, or other services for Members who have received emergency services but have not been discharged from a facility are granted an Expedited Review. Expedited Reviews are completed as promptly as the medical condition requires, but no later than three (3) days after the request.

Any grievance or appeal with Potential Quality of Clinical Care (PQOC) and/or Critical Incidents issues is referred to the Quality Improvement Department for further investigation and handling. Additionally, any identified issue related to the Privacy and Confidentiality of Protected Health Information (PHI) is referred to the Privacy Officer.

All grievance decisions are made within state established time frames not to exceed 90 calendar days from the day the initial grievance or appeal is received. However, the

grievance process timeframe may be extended up to 14 calendar days if the Member voluntarily agrees to an extension or the Managed Care Plan documents that additional information is needed, and the delay is in the enrollee's interest. If the timeframe is extended other than at the enrollee's request, the Managed Care Plan shall notify the enrollee within five business days of the determination, in writing, of the reason for the delay. All appeal decisions are made within state established time frames not to exceed 30 calendar days from the day the initial grievance or appeal is received. However, the appeal process timeframe may be extended up to 14 calendar days if the Member voluntarily agrees to an extension.

All aspects of the review process are documented and tracked in Molina's core data maintenance application and Grievance and Appeal database.

Members also have the right to appear in person and/or appoint a representative to act and speak on the Member's behalf at any point in the grievance and appeals process.

A member who has completed the Managed Care Plan's appeal process may file for a Medicaid Fair Hearing within 120 calendar days of receipt of the notice of plan appeal resolution. To request a Fair Hearing, Members/Member representative, should contact:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 7237
Tallahassee, FL 32314-7237

Phone: (877) 254-1055
Fax: (239) 338-2642
MedicaidHearingUnit@ahca.myflorida.com

Molina shall continue the Member's benefits if the Member or the Member's authorized representative submits a request for appeal within 10 business days after the Notice of Adverse Benefit Determination is mailed, or on or before the intended effective date of the action, whichever is later.

If the final resolution of the appeal is adverse to the Member and the action is upheld, Molina may recover the cost of services furnished to the Member while the appeal was pending to the extent they were furnished solely because of the continuation of benefits requirement.

Expedited appeal process and timeline

An appeal will be expedited in response to the clinical urgency of the situation; i.e., when a delay would jeopardize a Member's life or materially jeopardize a Member's health. A request to expedite may come from the Member, a provider, or when Molina feels it prudent to do so. An expedited appeal will be acted on quickly and a decision made within 48 hours.

Provider complaint process

Provider disputes and appeals

Molina is committed to the timely resolution of all provider complaints. Any disagreement regarding the processing, payment or non-payment of a claim is considered a Provider Dispute. Provider disputes are typically disputes related to underpayments, untimely filing, missing documents (i.e., consent forms, primary carrier explanation of benefits) and bundling issues. Provider Appeals are requests related to a denial of an authorization or medical criteria.

Providers disputing a Claim previously adjudicated must request such action within one year of Molina's original remittance advice date. A written acknowledgement letter will be mailed within three business days of receipt of a claim dispute or appeal. In addition, a written notice of the status of your request will be mailed every 30 days and thereafter until the case is resolved. Providers will be notified of Molina's decision in writing within 60 days of receipt of the claim dispute or appeal in accordance with 641.3155, F.S.

Molina has a dedicated staff for providers available to receive and resolve claim dispute and appeals. Molina offers the following submission options:

- Submit requests directly to Molina Healthcare of Florida via the Availity portal.
- Submit requests directly to Molina Healthcare of Florida via fax at: (877) 553-6504
- Submit Provider Disputes impacting more than 10 claims can be submitted via email to MFLClaimsDisputesProjects@MolinaHealthcare.com
- Submit Provider Appeal request to MFL_ProviderAppeals@MolinaHealthcare.com
- Submit Provider Disputes through the Contact Center at 866-472-4585 (Monday – Friday, 8am – 7pm)
- Submit requests via mail to:

  Molina Healthcare of Florida
  Appeal and Grievance Unit
  P.O Box 36030

Louisville, KY 40233-6030

Please note:

- Claims denied for missing documentation such as consent forms, explanation of benefits from primary carrier, or itemized bills are not disputes. These must be submitted and mailed with the copy of the claim to:

  Molina Healthcare of Florida
  P.O. BOX 22812
  Long Beach, CA 90801

- Requests for adjustments of claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original claim.

Capitol Bridge

If the Provider Dispute/Appeal results in an unfavorable decision, and the provider has additional documentation supporting their position, the provider may resubmit the Provider Dispute/Appeal for secondary review. In the alternative, providers may also request a review of their original appeal by the State's independent dispute resolution organization, listed below:

Capitol Bridge
Email Submissions to: FLCDR@capitolbridge.com

Tel: (800) 889-0549

Provider complaints not related to Claims

Providers with complaints not related to claims have 45 days to file a written complaint. A written acknowledgement letter will be mailed within three business days of receipt of complaint. In addition, a written notice of the status of your request will be mailed every 30 days and thereafter until the case is resolved. Providers will be notified of Molina's decision in writing within 90 days of receipt and provided written notice of the disposition and the basis of the resolution within three business days of resolution.

To file a Provider Complaint not related to claims, providers may contact Member Services at (866) 472- 4585, or send the request for review in writing, along with any supporting documentation to the address below:

Molina Healthcare of Florida

Appeal and Grievance Unit
P.O Box 36030
Louisville, KY 40233-6030

Provider Dispute/Appeal Form

Providers appealing or disputing a claim previously adjudicated must request such action within one (1) year of Molina's original remittance advice date. All claim appeals and disputes should be submitted on the Molina Provider Appeal/Dispute Form found on our website: MolinaHealthcare.com/providers/fl/medicaid/forms/fuf.aspx. Cases submitted without the Provider Appeal/Dispute Form may cause a delay in processing. The form must be complete and legible to aid in appeal or dispute processing along with a cover letter explaining reason for Appeal or Dispute. Only one claim is allowed for each Provider Appeal/Dispute form.

Appeals and Disputes being submitted for processing should be clearly marked as appeals and disputes and must include the following:

- Cover Letter/Appeal Dispute Form containing: Member Name, Member ID, Authorization Number (when applicable), Claim ID, DOS, Level of Appeal (1st or 2nd Level), Summary of reason for Appeal or Dispute clearly detailed.
- Complete medical records (for medical reviews).
- Copy of claim.
- Any supporting documentation to back up your appeal or dispute.

Subcontractor Complaints Information

Subcontractor Provider Complaints Information	
Transportation	Access2Care • Mailing Address: Access2Care,16331 Bay Vista Drive, Clearwater, FL 33760 • Contact Number: 844-814-4092 • Fax Number: 888-305-8246 • Email: SRTSouth@amr.net
Therapy	Health Network One • Mailing Address: Health Network One, Inc., P.O. Box 350590, Fort Lauderdale, FL 33335-0590 • Contact Number: 1.888.550.8800 • Fax Number: 305-620-5973 • Email: ATAFL@healthnetworkone.com

DME, Home Health, Home Infusion	Coastal Care • Mailing Address: Coastal Care Solutions, 1200 NW 78th Av, Suite 100, Doral, FL 33126 • Contact Number: 1-855-481-0505 • Website: www.ccsi.care
Vision	iCare Solutions • Mailing Address: iCare Provider Relations; 5440 Mariner Street, Suite 112, Tampa, FL 33609 • Contact Number (855) 373-7627 • Email: grievances@myicarehealth.com • Website: ehealthdeck.com/

CMS Preclusion List

All subcontractors delegated for Credentialing and/or Claims Administration must review their practitioner network against the CMS Preclusion list. The CMS Preclusion list will be provided to the subcontractor monthly by Molina. Within five business days of receipt, the subcontractor must review the list and identify any practitioners with a new preclusion since the last publication date. Within 15 calendar days of receipt of the list, the subcontractor must notify Molina of any identified practitioner(s), including a report of all Molina claims paid to the provider in the previous 12 months. Depending on delegated expectations, subcontractors may also be responsible for sending the necessary Member notification at least 60 calendar days prior to the Preclusion effective date, informing the Member of the need to select a new practitioner.

Note: Member notification responsibilities depend on the functions delegated and the services provided. Not all subcontractors are responsible for this piece, and in some cases, are required to send the appropriate information to Molina so that Molina can notify impacted Members. If there are questions about subcontractor responsibilities related to Member notification of precluded providers, please contact your Molina Delegation Oversight contact.

Reporting

Grievance and appeal trends are reported to the Quality Improvement Committee quarterly. This trend report includes a quantitative review of trends, qualitative or barriers analysis, and identification of interventions that address key drivers. An annual evaluation of grievance and appeal analysis is then completed and presented to the Quality Improvement Health Equity Transformation Committee for evaluation. If

required by the state or CMS, reporting is submitted to the appropriate agency as needed.

Record retention

Molina will maintain all grievance and related appeal documentation on file for a minimum of 10 years. In addition to the information documented electronically in Molina's core processing system or maintained in other electronic files, Molina will retain copies of any written documentation submitted by the provider pertaining to the grievance/appeal process. Provider shall maintain records for a period not less than 10 years from the termination of the Model Contract and retain them further if the records are under review or audit until the review or audit is complete. (Provider shall request and obtain Health Plan's prior approval for the disposition of records if Agreement is continuous.)

14. Credentialing and recredentialing

The purpose of the Credentialing program is to assure Molina Healthcare, and its subsidiaries (Molina) network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of Molina to provide superior health care to the community. Additional information is available in the Credentialing Policy and Procedure which can be requested by contacting your Molina Provider Services representative.

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

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

Non-discriminatory credentialing and recredentialing

Molina does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation, ancestry, religion, marital status, health status, or patient types (e.g., Medicaid) in which the Practitioner specializes. This does not preclude Molina from

including in its network Practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of Members.

Credentialing Turnaround Time

Molina completes initial credentialing of Practitioners within 60 calendar days. The 60 calendar days is measured from the date Molina receives a full and complete credentialing application.

Types of Practitioners credentialed & recredentialed

Practitioners and groups of Practitioners with whom Molina contracts must be credentialed prior to the contract being implemented.

Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral health care Practitioners who are licensed, certified, or registered by the State to practice independently
- Chiropractors
- Clinical Social Workers
- Dentists
- Doctoral or master's-level psychologists
- Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists
- Master's-level clinical social workers
- Master's-level clinical nurse specialists or psychiatric nurse practitioners
- Medical Doctors (MD)
- Naturopathic Physicians
- Nurse Midwives
- Nurse Practitioners
- Occupational Therapists
- Optometrists
- Oral Surgeons
- Osteopathic Physicians (DO)
- Pharmacists
- Physical Therapists
- Physician Assistants

- Podiatrists
- Psychiatrists and other physicians
- Speech and Language Pathologists
- Telemedicine Practitioners

Criteria for participation in the Molina network

Molina has established criteria, and the sources used to verify these criteria for the evaluation and selection of Practitioners for participation in the Molina network. These criteria have been designed to assess a Practitioner's ability to deliver care. This policy defines the criteria applied to applicants for initial participation, recredentialing and ongoing participation in the Molina network. To remain eligible for participation, Practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentation provided by Molina.

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

Practitioners must meet the following criteria to be eligible to participate in the Molina network. The Practitioner shall have the burden of producing adequate information to prove they meet all criteria for initial participation and continued participation in the Molina network. If the Practitioner fails to provide this information, the credentialing application will be deemed incomplete, and it will result in an administrative denial or administrative termination from the Molina network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

- Application – Provider must submit to Molina a complete credentialing application either from CAQH ProView or other State mandated practitioner application. The attestation must be signed within 120 days. Application must include all required attachments.
- License, certification or registration – Practitioners must hold a current and valid license, certification, or registration to practice in their specialty in every State in which they will provide care and/or render services for Molina Members. Telemedicine Practitioners are required to be licensed in the State where they are located and the State where the member is located.

- Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate – Provider must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Providers must have a DEA or CDS in every State where the Provider provides care to Molina Members. If a Practitioner has never had any disciplinary action taken related to their DEA and/or CDS and has a pending DEA/CDS certificate or chooses not to have a DEA and/or CDS certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA and/or CDS certificate to write all prescriptions requiring a DEA number.
- Specialty – Provider must only be credentialed in the specialty in which they have adequate education and training. Providers must confine their practice to their credentialed area of practice when providing services to Molina Members.
- Education –Provider must have graduated from an accredited school with a degree required to practice in their designated specialty.
- Residency training – Provider must have satisfactorily completed residency programs from accredited training programs in the specialties in which they are practicing. Molina only recognizes residency 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), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, podiatric residencies are required to be three years in length. If the podiatrist has not completed a three-year residency or is not board certified, the podiatrist must have five years of work history practicing podiatry.
- Fellowship training – If the Provider is not board certified in the specialty in which they practice and has not completed a residency program in the specialty in which they practice, they must have completed a fellowship program from an accredited training program in the specialty in which they are practicing.
- Board certification – Board certification in the specialty in which the Practitioner is practicing is not required. Initial applicants who are not board certified will be considered for participation if they have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing. Molina recognizes board certification only from the following Boards:
  - American Board of Medical Specialties (ABMS)
  - American Osteopathic Association (AOA)
  - American Board of Foot and Ankle Surgery (ABFAS)

- American Board of Podiatric Medicine (ABPM)
- American Board of Oral and Maxillofacial Surgery
- American Board of Addiction Medicine (ABAM)
- College of Family Physicians of Canada (CFPC)
- Royal College of Physicians and Surgeons of Canada (RCPSC)
- Behavioral Analyst Certification Board (BACB)
- National Commission on Certification of Physician Assistants (NCCPA)

- General practitioners – Practitioners 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 Practitioner in the Molina network. To be eligible, the Practitioner must have maintained primary care practice in good standing for a minimum of the most recent five years without any gaps in work history. Molina will consider allowing a Practitioner who is/was board certified and/or has residency training in a specialty other than primary care to participate as a General Practitioner if the Practitioner is applying to participate as a Primary Care Physician (PCP), Urgent Care, or Wound Care. Participating General Practitioners providing only wound care services do not require five years of work history as a PCP.
- Nurse Practitioners & Physician Assistants – In certain circumstances, Molina may credential a Practitioner who is not licensed to practice independently. In these instances, it would also be required that the Practitioner providing the supervision and/or oversight be contracted and credentialed with Molina.
- Work history – Provider must supply the most recent five years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six months, the Practitioner must clarify the gap verbally or in writing. The organization will document verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds one year, the Practitioner must clarify the gap in writing.
- Malpractice history – Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application.
- State sanctions, restrictions on licensure or limitations on scope of practice – Practitioner must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations, and non-renewals. Practitioner must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure

questions on the application, a detailed response is required from the Practitioner. Molina will also verify all licenses, certifications, and registrations in every State where the Practitioner has practiced. At the time of initial application, the Practitioner must not have any pending or open investigations from any state or governmental professional disciplinary body[3]. This would include Statement of Charges, Notice of Proposed Disciplinary Action, or the equivalent.

- Medicare, Medicaid and other sanctions and exclusions – Practitioner 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. Practitioners must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Practitioner 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 Practitioner.
- Medicare Opt-Out – Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- Social Security Administration Death Master File – Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.
- Medicare Preclusion List – Practitioners currently listed on the Preclusion List may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- Professional liability insurance – Practitioner must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the Practitioner's activities on Molina's behalf. Practitioners maintaining coverage under a Federal tort or self-insured are not required to include amounts of coverage on their application for professional or medical malpractice insurance.
- Inability to perform – Practitioner must disclose any inability to perform essential functions of a Practitioner in their area of practice with or without reasonable

[3] 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.

accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.

- Lack of present illegal drug use – Practitioners must disclose if they are currently using any illegal drugs/substances.
- Criminal convictions – Practitioners must disclose if they have ever had any criminal convictions. Practitioners must never have been convicted, including guilty pleas and adjudicated pretrial diversions for crimes against person such as murder, rape, assault and other similar crimes. Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes. Any crime that placed the Medicaid or Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct. Any crime that would result in mandatory exclusion under section 1128 of the Social Security Act. Any crime related to fraud, kickbacks, health care fraud, claims for excessive charges, unnecessary services or services which fail to meet professionally recognized standards of healthcare, patient abuse or neglect, controlled substances, or similar crimes. At the time of initial credentialing, practitioner must not have any pending criminal charges in the categories listed above.
- Loss or limitations of clinical privileges – At initial credentialing, Practitioners must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At recredentialing, Practitioners must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges since the previous credentialing cycle.
- Hospital privileges – Practitioners must list all current hospital privileges on their credentialing application. If the Practitioner has current privileges, they must be in good standing.
- National Provider Identifier (NPI) – Practitioners must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS).

Notification of discrepancies in credentialing information and Practitioner's right to correct erroneous information

Molina will notify the Practitioner immediately in writing in the event credentialing information obtained from other sources varies substantially from that submitted by the Practitioner. Examples include but are not limited to actions on a license, malpractice claims history, board certification, sanctions, or exclusions. Molina is not

required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by Law.

Practitioners have the right to correct erroneous information in their credentials file. Practitioner's rights are published on the Molina website and are included in this Provider Manual.

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

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

Molina Healthcare, Inc.
Attention: Credentialing Director
PO Box 2470
Spokane, WA 99210

Upon receipt of notification from the Practitioner, Molina will document receipt of the information in the Practitioner's credentials file. Molina will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the Practitioner's credentials file. The Practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with the Practitioner's information, the Credentialing Department will notify the Practitioner.

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

Practitioner's right to review information submitted to support their credentialing application

Practitioners have the right to review their credentials file at any time. Practitioner's rights are published on the Molina website and are included in this Provider Manual.

The Practitioner must notify the Credentialing Department and request an appointed time to review their file and allow up to seven calendar days to coordinate schedules. The Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The Practitioner 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 Practitioner are documents, which the Practitioner sent to Molina (e.g., the application and any other attachments submitted with the application from the Practitioner). Practitioners may not copy any other documents from the credentialing file.

Practitioner's right to be informed of application status

Practitioners have a right, upon request, to be informed of the status of their application by telephone, email, or mail. Practitioner's rights are published on the Molina website and are included in this Provider Manual. Molina will respond to the request within two working days. Molina will share with the Practitioner where the application is in the credentialing process and note any missing information or information not yet verified.

Professional Review Committee (PRC)

Molina designates a PRC to make recommendations regarding credentialing decisions using a peer review process. Molina works with the PRC to assure that network Practitioners are competent and qualified to provide continuous quality care to Molina members. The PRC reports to the Quality Improvement Committee (QIC.) Molina utilizes information such as, but not limited to credentialing verifications, QOCs, and member complaints to determine continued participation in Molina's network or if any adverse actions will be taken. Certain PRC decisions may be appealed. To utilize this process, providers should request a fair hearing as outlined below and in Molina's policy. Please contact Molina Provider Relations representatives for additional information about fair hearings.

Notification of Credentialing Decisions

Initial credentialing decisions are communicated to Practitioners via letter or email. This notification is typically sent by the Molina Medical Director within two weeks of the decision. Under no circumstance will notifications letters be sent to the

Practitioners later than 60 calendar days from the decision. Notification of recredentialing approvals is not required.

Recredentialing

Molina recredentials every Practitioner at least every 36 months.

Excluded providers

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

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

Ongoing monitoring of sanctions and exclusions

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

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

- Medicare Exclusion Database (MED) – Molina monitors for Medicare exclusions through the Centers for Medicare and Medicaid Services (CMS) MED online application site.
- Medicare Preclusion List – Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- National Practitioner Database – Molina enrolls all credentialed Practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- System for Award Management (SAM) – Monitor for Providers sanctioned with SAM.

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

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

Active patient load attestation

Practitioners must complete, sign and date an 'Attestation and Release of Information' form attesting to their active patient load. The form must be completed in its entirety by answering the following questions:

- Practitioner's patient load (all patient populations including but not limited to Medicaid fee for service; Children's Medical Services Network; SMMC plans; Medicare; KidCare, and commercial coverage) is no more than 3,000 patients per PCP.
- An active patient is seen by the Practitioner a minimum of three times a year.
- The Practitioner is eligible to become a Medicaid provider.

Provider Appeal Rights

In cases where the Credentialing Committee suspends or terminates a Provider's contract based on quality of care or 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.

15. Delegation

Delegation is a process that gives another entity the ability to perform specific functions on behalf of Molina. Molina may delegate:

1. Utilization management
2. Credentialing and recredentialing
3. Claims
4. Complex case management
5. CMS Preclusion List monitoring
6. Other clinical and administrative functions

When Molina delegates any clinical or administrative functions, Molina remains responsible to external regulatory agencies and other entities for the performance of the delegated activities, including functions that may be sub-delegated. To become a delegate, the Provider/accountable care organization (ACO)/vendor must be in compliance with Molina's established delegation criteria and standards. Molina's Delegation Oversight Committee (DOC) or other designated committee, must approve all delegation and sub-delegation arrangements. To remain a delegate, the Provider/ACO/vendor must maintain compliance with Molina's standards and best practices.

Delegation reporting requirements

Delegated entities contracted with Molina must submit monthly and quarterly reports. Such reports will be determined by the function(s) delegated and will be reviewed by Molina delegation oversight staff for compliance with performance expectations within the timeline indicated by Molina.

Corrective action plans and revocation of delegated activities

If it is determined that the delegate is out of compliance with Molina's guidelines or regulatory requirements, Molina may require the delegate to develop a corrective action plan designed to bring the delegate into compliance. Molina may also revoke delegated activities if it is determined that the delegate cannot achieve compliance or if Molina determines that is the best course of action.

If you have additional questions related to delegated functions, please contact your Molina Contract Manager.

16. Pharmacy

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. The goal of Molina is to provide our members with high-quality, cost-effective drug therapy. Molina works with our providers and pharmacists to ensure medications used to treat a variety of conditions and diseases are offered. Molina covers prescription and certain over-the-counter drugs.

Pharmacy and Therapeutics Committee

The State (AHCA) Pharmacy and Therapeutics Committee (P&T) meets quarterly to review and recommend medications for formulary consideration. The P&T Committee is organized to assist with managing pharmacy resources and to improve the overall satisfaction of members and providers. It seeks to ensure all Florida Medicaid members receive appropriate and necessary medications. The Committee voting membership consists of external physicians and pharmacists from various clinical specialties.

Pharmacy network

Members must use their Molina ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, limitations, and network pharmacies is available by visiting MolinaHealthcare.com or calling Molina at (855) 322-4076.

Drug formulary

The pharmacy program does not cover all medications. The State (AHCA) keeps a list of drugs, devices, and supplies that are covered under the plan's pharmacy benefit. The list shows all the prescription and over-the-counter products Members can get from a pharmacy. Some medications require prior authorization (PA) or have limitations on age, dosage and/or quantities. For a complete list of covered medications please visit Pharmacy Policy (myflorida.com).

Information on procedures to obtain these medications is described within this document and also available on the website at MolinaHealthcare.com.

Formulary medications

In some cases, patients may only be able to receive certain quantities of medication. Information on limits is included and can be found in the Formulary document.

Formulary medications with PA may require first-line medications before they are approved.

Quantity limitations

Quantity limitations have been placed on certain medications to ensure safe and appropriate use of the medication.

Age limits

Some medications may have age limits. Age limits align with current U.S. Food and Drug Administration (FDA) alerts for the appropriate use of pharmaceuticals.

Step therapy

Plan restrictions for certain Formulary drugs may require that other drugs be tried first. The Formulary designates drugs that may process under the pharmacy benefit without prior authorization if the Member's pharmacy fill history with Molina shows other drugs have been tried for certain lengths of time. If the Member has trialed certain drugs prior to joining Molina, documentation in the clinical record can serve to satisfy requirements when submitted to Molina for review. Drug samples from Providers or manufacturers are not considered as meeting step therapy requirements or as justification for exception requests.

Plan restrictions for certain Formulary drugs may require that other drugs be tried first. The Formulary designates drugs that may process under the pharmacy benefit without prior authorization if the Member's pharmacy fill history with Molina shows other drugs have been tried for certain lengths of time. If the Member has trialed certain drugs prior to joining Molina, documentation in the clinical record can serve to satisfy requirements when submitted to Molina for review. Drug samples from Providers or manufacturers are not considered as meeting step therapy requirements or as justification for exception requests.

Non-formulary medications

Non-Formulary medications may be considered for exception when Formulary medications are not appropriate for a particular patient or have proven ineffective. Requests for Formulary Exceptions should be submitted using a PA form. Clinical evidence must be provided and is taken into account when evaluating the request to determine medical necessity. The use of manufacturer's samples of Non-Formulary or "Prior Authorization Required" medications does not override Formulary requirements.

Generic substitution

Generic drugs should be dispensed whenever available unless the State (AHCA) lists the corresponding brand name drug as preferred on their drug list. If the use of a particular brand name becomes medically necessary as determined by the Provider, PA must be obtained through the standard PA process.

New-to-market drugs

Newly approved drug products will not normally be placed on the Formulary during their first three to six months on the market until they are reviewed by the State (AHCA) P&T committee. During this period, access to these medications will be considered through the PA process.

Medications not covered

Medications not covered by Medicaid are excluded from coverage. For example, drugs used in the treatment of fertility or those used for cosmetic purposes are not part of the benefit.

Submitting a prior authorization request

Molina will only process completed PA request forms. The following information MUST be included for the request form to be considered complete:

- Member First name, Last Name, Date of Birth, and Identification number
- Prescriber first name, last name, NPI, phone number and fax number
- Drug name, strength, quantity, and directions of use
- Diagnosis

If information is missing, the data entry team will first attempt to call your office to obtain the information. If unsuccessful, a fax will be generated and sent requesting the missing information.

Molina's decisions are based upon the information included with the PA request. Clinical notes are recommended. Some medications, such as those listed with (SP) Specialty on the Preferred Formulary require clinical notes for review. If clinical information and/or medical justification is missing, Molina will either fax or call your office to request that the clinical information be sent for review. To avoid delays in decisions, be sure to complete the PA form in its entirety, including medical justification and/or supporting clinical notes.

Fax a completed Pharmacy Prior Authorization/Exception Form to Molina at (866) 236-8531. A blank Pharmacy Prior Authorization/Exception Form may be obtained by accessing MolinaHealthcare.com or by calling (855) 322-4076.

Member and provider "patient safety notifications"

Molina has a process to notify Members and Providers regarding a variety of safety issues which include voluntary recalls, FDA required recalls and drug withdrawals for patient safety reasons. This is also a requirement as an NCQA-accredited organization.

Specialty pharmaceuticals, injectable and infusion services

Many specialty medications are covered by Molina through the pharmacy benefit using national drug codes (NDCs) for billing and specialty pharmacy for dispensing to the patient or provider. Some of these same medications may be covered through the medical benefit using Healthcare Common Procedure Coding System (HCPCS) via paper or electronic medical claim submission.

During the utilization management review process, Molina will review the requested medication for the most cost-effective, yet clinically appropriate benefit (medical or pharmacy) of select specialty medications. All reviewers will first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to determination of benefit processing.

Molina may conduct a peer-to-peer discussion or other outreach to evaluate the level of care that is medically necessary. If an alternate site of care is suitable, Molina may offer the ordering Provider help in identifying an in-network infusion center, physician office or home infusion service and will help the Member coordinate and transition through case management.

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

Specialty pharmacies of your choice in the Molina specialty pharmacy network are Publix Specialty and CVS Caremark Specialty for our Medicaid and Marketplace members. To use Publix Specialty, fax prescriptions to 1-863-413-5723 / phone prescriptions to (855) 797-8254 (no enrollment form necessary). To use CVS Specialty, fax prescriptions to 1-800-323-2445. Members can transfer specialty prescriptions between CVS Caremark and Publix.

Newly FDA-approved medications are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the State (AHCA) Pharmacy and Therapeutics Committee. "Buy-and-bill" drugs are pharmaceuticals which a provider purchases and administers, and for which the provider submits a claim to Molina Healthcare for reimbursement.

Pain safety initiative (PSI) resources

Safe and appropriate opioid prescribing and utilization is a priority for all of us in health care. Molina requires Providers to adhere to Molina's drug formularies and prescription policies designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to Members regarding Opioid and pain safety as needed.

Molina is dedicated to ensuring Providers are equipped with additional resources, which can be found on the Molina Provider website. Providers may access additional Opioid-safety and Substance Use Disorder resources at MolinaHealthcare.com under the Health Resource tab and the Provider Training tab. Please consult with your Provider Services Representative or reference the medication formulary for more information on Molina's Pain Safety Initiatives.

Community Engagement

Coordination with Outside Organizations

Understanding that members will require assistance outside of those services typically provided by physicians and hospitals, and in the spirit of our Mission of removing barriers to care, Molina has developed relationships with various outside organizations to assist in improving the overall health outcome of our enrollees. Molina's Case Managers and Community Connectors are trained to identify hardships that impact enrollees' health, including basic needs such as, proper housing, utilities, food, and clothing. Through partnerships with faith-based and community-based

organizations, Case Managers and Community Connectors can assist members in obtaining services they may not know are available.

There are additional resources available at no-cost for members and their families.

Hope Florida

The state of Florida offers a program called Hope Florida. Hope Florida uses Hope Navigators to guide Floridians on a path to prosperity.

Services that Hope Navigators can help with:

- Identifying goals and barriers
- Referrals to local, community-based partners
- One-on-one support to develop a plan to achieve economic sufficiency

If members need to connect with a Hope Navigator, they can also call the Hope Line at 1-850-300-HOPE (1-850-300-4673).

Molina Help Finder

Molina Help Finder can help members find community resources. The Molina Help Finder online tool help members search for local programs and resources to meet basic needs, such as job training, childcare, transportation and more. Molina Help Finder is available in more than 120 languages and is a free resource.

Molina Services and Programs

Molina Healthcare of Florida's voluntary Care Management program is for members with ongoing health problems and offers resources to help caregivers. This includes help with transportation, setting up appointments and connecting members and caregivers with resources that can help them live a healthier life. Members can call us for more information at (866) 472-4585 (TTY: 711).

Community Partnerships to Improve Outcomes (CPIO)

The Managed Care Plan has established community partnerships that provide services to individuals in the community, to assist with programs and resources to meet basic needs.

These organizations meet the requirements of the Agency's Community Partnerships to Improve Outcomes (CPIO) priority areas described below:

- Birth Outcomes (MMA)
- Mental Health of Children and Adolescents (MMA)
- Health-Related Social Needs (MMA)
- Chronic Diseases (LTC)
- Mental Health (LTC)
- Health-Related Social Needs (LTC)
- Home and Community-based services and support (LTC)

Molina Healthcare and its Provider Network are required to refer enrollees to community-based services to assist the member with their basic needs. Molina will provide access and training to our providers/CBOs, including access to our Care Coordination Portal (CCP) and a description of what services are available for Molina members. Molina Healthcare will document in the enrollee record shared by providers any referrals to CBOs and follow up on the enrollee's receipt of services from the community program using a closed-loop referral system of record.

17. Long-Term Care Program

LTC overview

Long-Term Care (LTC) services are provided when an individual is living in a facility-based care setting (such as a nursing home or intermediate care facility). The program empowers consumers to take an active role in their health care. The programs serve older adults, people with intellectual and/or developmental disabilities and people with disabilities.

The Agency for Health Care Administration (AHCA) administers the Statewide Medicaid Managed Care (SMMC) Long-Term Care program, sets coverage policy, and gets those eligible for services enrolled in a LTC plan. The Department of Children and Families (DCF) is responsible for determining financial eligibility for services. The Department of Elder Affairs (DOEA) is responsible for determining medical eligibility and level of care needed.

Please see the Benefits and Covered Services section of this manual for the list of LTC services covered by Molina.

Claims for MLTSS services

Providers are required to bill Molina for all MLTSS waiver services through mail, electronically, using EDI submission or through the Availity portal. After registering on

the Availity portal a Provider will be able to check eligibility, Claim status and create/submit Claims to Molina.

For information on how to submit a Claim via the Availity portal contact Provider Services.

Electronic visit verification (EVV)

In accordance with CMS regulations, the delivery of all home health services to Medicaid recipients must be electronically verified.

Providers must maintain a minimum of an 85% compliance rate, the other 15% is to allow providers to have margin of errors which can be appeal if is any of the extenuating circumstance mentioned below applies.

All manually submitted home health claims will be denied. However, providers may submit an appeal if any of the below apply:

Exceptions

Molina will only honor exceptions submitted due to the use of a temporary provider that is filling in for the assigned attendant/staff or due to service interruption resulting from a natural disaster or State declared emergency.

Extenuating Circumstances

- Provider is not loaded in the EVV platform.
- Continuity of Care concern
- Authorization was not entered in the EVV platform timely.
- Authorization was entered retrospectively on the platform (Example: Authorization is for 1/1/24 – 3/31/24 but was not entered in the EVV platform until 1/15/24. All visits from 1/1/24 - 1/15/24 would be allowed)
- Providers who report EVV barriers

Appeals must include clinical documentation evidencing that the visit was completed, the date/time, and any extenuating circumstances that prevented the visit from being electronically verified. Timesheets are not considered evidence of visit completion. Should you have any questions, please contact HHAeXchange via their Support Portal

at www.hhaexchange.com or Molina Healthcare at (855) 322-4076 or via e-mail at MFLProviderServicesManagement@molinahealthcare.com.

17. Glossary of terms

Action – The denial or limited Authorization of a requested service, including the type, level, or provider of service; reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; or failure to provide services or act in a timely manner as required by law or contract.

Acute Inpatient Care – Care provided to persons sufficiently ill or disabled requiring:

I. Constant availability of medical supervision by attending Provider or other medical staff
II. Constant availability of licensed nursing personnel
III. Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to ensure proper medical management by the Provider

AHCA – Agency for Health Care Administration

Ambulatory Care – Health services provided on an outpatient basis. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient has come to a location other than his/her home to receive services and has departed the same day. Examples include chemotherapy and physical therapy.

Ambulatory Surgical Facility – A facility licensed by the state where it is located, equipped, and operated mainly to provide for surgeries and obstetrical deliveries, and allows patients to leave the facility the same day surgery or delivery occurs.

Ancillary Services – Health services ordered by a Provider, including but not limited to laboratory services, radiology services, and physical therapy.

Appeal – An oral or written request by a Member or Member's personal representative received at Molina Healthcare for review of an action.

Authorization – Approval obtained by Providers from Molina Healthcare for a designated service before the service is rendered. Used interchangeably with preauthorization or prior Authorization.

Average Length of Stay (ALOS) – Measure of hospital utilization calculated by dividing total patient days incurred by the number of admissions/discharges during the period.

Capitation – A prospective payment based on a certain rate per person paid on a monthly basis for a specific range of health care services.

Centers for Medicare & Medicaid Services (CMS) – A federal agency within the U.S. Department of Health and Human Services. CMS administers Medicare, Medicaid, and SCHIP programs.

Children With Special Health Care Needs (CSHCN) – Children identified by HRSA as meeting the federal guidelines under Title V of the Social Security Act (SSA). Any child (birth to (18) years of age) with a health or developmental problem requiring more than the usual pediatric health care.

Claim – A request for payment for the provision of Covered Services prepared on a CMS-1500 form, UB-04 (CMS-1450), or successor, submitted electronically.

Coordination of Benefits (COB) – Applies when a person is covered under more than one group medical plan. The plans coordinate with each other to avoid duplicate payments for the same medical services.

Complaint – Any written or oral expression of dissatisfaction.

Covered Services – Medically necessary services included in the state contract. Covered services change periodically as mandated by federal or state legislation.

Credentialing – The verification of applicable licenses, certifications, and experience to assure that Provider status be extended only to professional, competent Providers who continually meet the qualifications, standards, and requirements established by Molina Healthcare.

Current Procedural Terminology (CPT) Codes – American Medical Association (AMA) approved standard coding for billing of procedural services performed.

Delivery System – The mechanism by which health care is delivered to a patient. Examples include, but are not limited to, hospitals, Providers' offices, and home health care.

Denied Claims Review – The process for Providers to request a review of a denied claim.

Discharge Planning – Process of screening eligible candidates for continuing care following treatment in an acute care facility, and assisting in planning, scheduling, and arranging for that care.

Durable Medical Equipment (DME) – Equipment used repeatedly or used primarily and customarily for medical purposes rather than convenience or comfort. It also is equipment appropriate for use in the home and prescribed by a Provider.

Dual Coverage – When a Member is enrolled with two Molina Healthcare plans at the same time.

Electronic Data Interchange (EDI) – The electronic exchange of information between two or more organizations.

Early Periodic Screening Diagnosis and Treatment Program (EPSDT) – A package of services in a preventive (well child) exam covered by Medicaid as defined in the SSA section 1905 (R). Services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for: vision, dental, substance abuse, mental health, and hearing, as well as any medically necessary services found during the EPSDT exam.

Emergency Care – The provision of medically necessary services required for the immediate attention to evaluate or stabilize a Medical Emergency (See definition below).

Encounter Data – Molina Healthcare shall collect, and submit to the Agency's fiscal agent, enrollee service level encounter data for all covered services.

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.

Expedited Appeal – An oral or written request by a Member or Member's personal representative received by Molina Healthcare requesting an expedited reconsideration of an action when taking the time for a standard resolution could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function; or

would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Expedited Grievance – A grievance where delay in resolution would jeopardize the Member's life or materially jeopardize the Member's health.

Federally Qualified Health Center (FQHC) – A facility that is:

I. Receiving grants under section 329, 330, or 340 of the Public Health Services Act
II. Receiving such grants based on the recommendation of AHCA within the Public Health Service, as determined by the Secretary to meet the requirements for receiving such a grant
III. A tribe or tribal organization operating outpatient health programs or facilities under the Indian Self Determination Act (PL93-638)

Fee-For-Service (FFS) – FFS is a term Molina Healthcare uses to describe a method of reimbursement based upon billing for a specific number of units of services rendered to a Member.

Grievance – An oral or written expression of dissatisfaction by a Member, or representative on behalf of a Member, about any matter other than an action received at Molina Healthcare.

Health Plan Employer Data and Information Set (HEDIS) – Set of standardized measures developed by NCQA. Originally HEDIS was designed to address private employers' needs as purchasers of health care. It has since been adapted for use by public purchasers, regulators, and consumers. HEDIS is used for quality improvement activities, health management systems, Provider profiling efforts, an element of NCQA accreditation, and as a basis of consumer report cards for managed care organizations.

HIPAA – Health Insurance Portability and Accountability Act

Independent Practice Association (IPA) – A legal entity, the Members of which are independent Providers who contract with the IPA for the purpose of having the IPA contract with one or more health plans.

Independent Review Organization (IRO) – A review process by a state-contracted independent third party.

Medicaid – The state and federally funded medical program created under Title XIX of the SSA.

Medical Emergency – Circumstances which a reasonably prudent person would regard as the unexpected onset of sudden or acute illness or injury requiring immediate medical care such that the Member's life or health would have been jeopardized had the care been delayed.

Medical Records – A confidential document containing written documentation related to the provision of physical, social, and mental health services to a Member.

Medically Necessary Services – FS 409.9131 (2) (b) Any goods or services necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. In making determinations of medical necessity, the agency must, to the maximum extent possible, use a physician in active practice, either employed by or under contract with the agency, of the same specialty or subspecialty as the physician under review. Such a determination must be based upon the information available at the time the goods or services were provided.

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the SSA. Medicare has two parts:

- Part A covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- Part B is the supplementary medical insurance benefit (SMIB) covering the Medicare Provider's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

Member – A current or previous Member of Molina Healthcare.

NCQA – National Committee for Quality Assurance

Participating Provider – A Provider that has a written agreement with Molina Healthcare to provide services to Members under the terms of their agreement.

Provider Group – A partnership, association, corporation, or other group of Providers.

Physician Incentive Plan – Any compensation arrangement between a health plan and a Provider or Provider group that may directly or indirectly have the effect of reducing or limiting services to Members under the terms of the agreement.

Preventive Care – Health care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination and immunization.

Primary Care Provider (PCP) – A participating Provider responsible for supervising, coordinating, and providing primary health care to Members, initiating referrals for specialist care, and maintaining the continuity of Member care. PCPs include, but are not limited to; Pediatricians, Family Practice Providers, General Medicine Providers, Internists, Obstetrician/Gynecologists, Physician Assistants (under the supervision of a Physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by Molina Healthcare.

Quality Improvement Program (QIP) – A formal set of activities provided to assure the quality of clinical and non-clinical services. QIP includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process.

Remittance Advice (RA) – Written explanation of processed claims.

Referral – The practice of sending a patient to another Provider for services or consultation which the referring Provider is not prepared or qualified to provide.

Rural Health Clinic (RHC) – A clinic, located in a rural area, designated by the Department of Health as an area having either a shortage of personal health services or a shortage of primary medical care. These clinics are entitled to receive enhanced payments for services provided to enrolled Members.

Service Area – A geographic area serviced by Molina Healthcare, designated, and approved by AHCA.

Specialist – Any licensed Provider who practices in a specialty field such as Cardiology, Dermatology, Oncology, Ophthalmology, Radiology, etc.

Florida Kidcare/State Children's Health Insurance Plan (SCHIP) – A federal/state funded health insurance program authorized by Title XXI of the SSA and administered by HRSA.

Supplemental Security Income (SSI) – A federal cash program for aged, blind, or disabled persons, administered by the SSA.

Sub-Contract – A written agreement between a health plan and a participating Provider, or between a participating Provider and another sub-contractor, to perform all or a portion of the duties and obligations a plan is required to perform pursuant to the agreement.

Telemedicine — The practice of health care delivery by a practitioner who is located at a site other than the site where the patient is located for the purposes of evaluation, diagnosis, or recommendation of treatment.

Tertiary Care – Care requiring high-level intensive, diagnostic and treatment capabilities for adults and/or children, typically administered at highly specialized medical centers.

Third Party Liability (TPL) – A company or entity other than Molina Healthcare liable for payment of health care services rendered to Members. Molina Healthcare will pay claims for covered benefits and pursue a refund from the third party when liability is determined.

Title V – The portion of the federal SSA that authorizes grants to states for the care of CSHCN.

Title XIX – The portion of the federal SSA that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Title XXI – The portion of the federal SSA that authorizes grants to states for SCHIP.

Utilization Management (UM) – The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing assistance to a clinician or patient in cooperation with other parties, to ensure appropriate use of resources. UM includes prior Authorization, concurrent review, retrospective review, discharge planning and case management.

Well Child Visit (formerly known as CHCUP) – Early Periodic Screening Diagnosis and Treatment Program

Molina Healthcare of Florida, Inc.
8300 NW 33rd Street, Suite 400
Doral, FL 33122

Phone: (855) 322-4076