Molina Healthcare of Florida, Inc. Provider Orientation

2025

MOLINA HEALTHCARE

You Matter to Molina

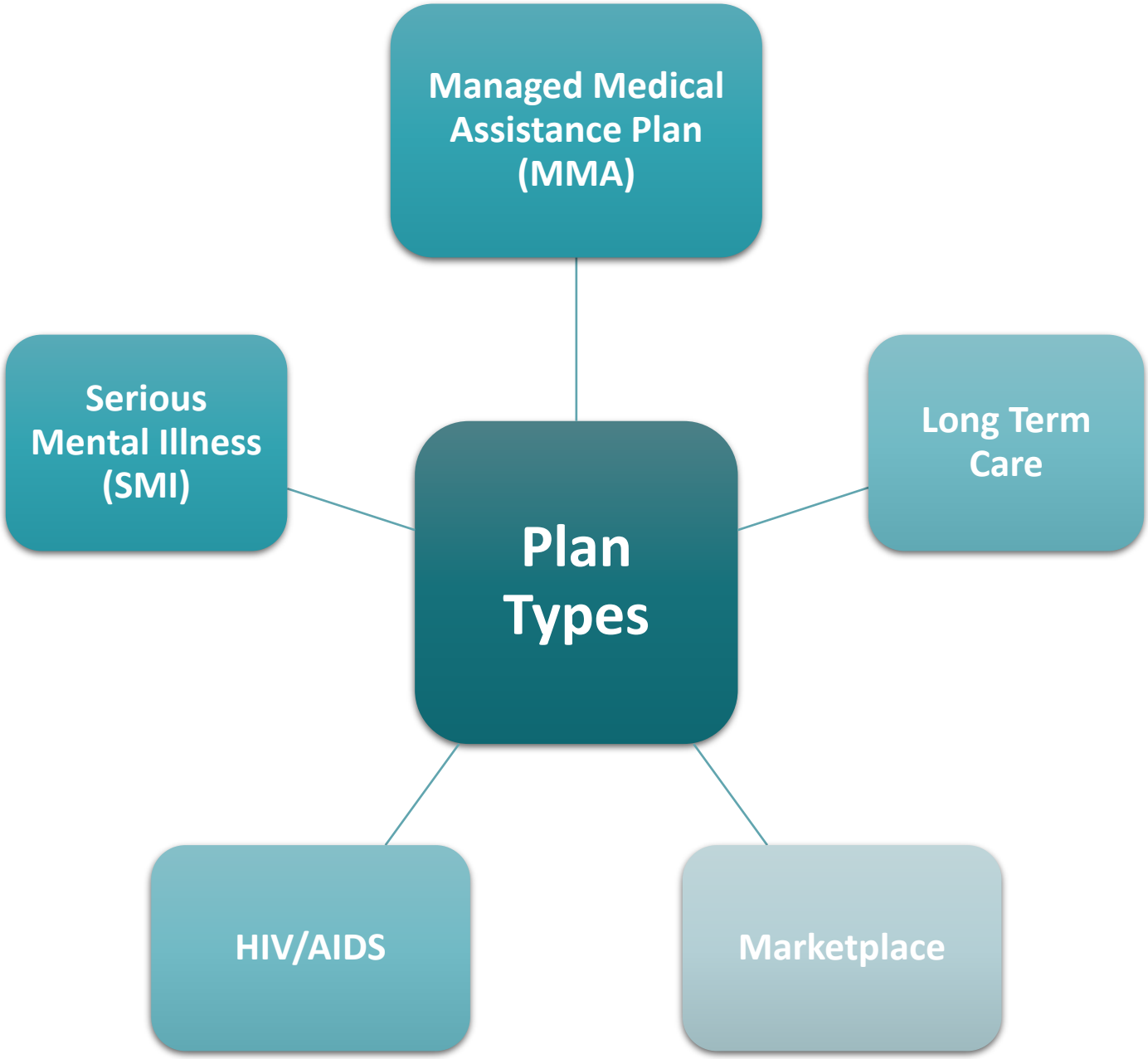
Overview

Welcome to the Molina provider network Statewide Medicaid Managed Care (SMMC) Provider Orientation. Molina Healthcare is a Comprehensive Plus Plan that provides services for enrollees in Managed Medical Assistance (MMA), Long-Term Care (LTC), HIV/AIDS and SMI Specialty Products across Miami-Dade and Monroe counties in Florida.

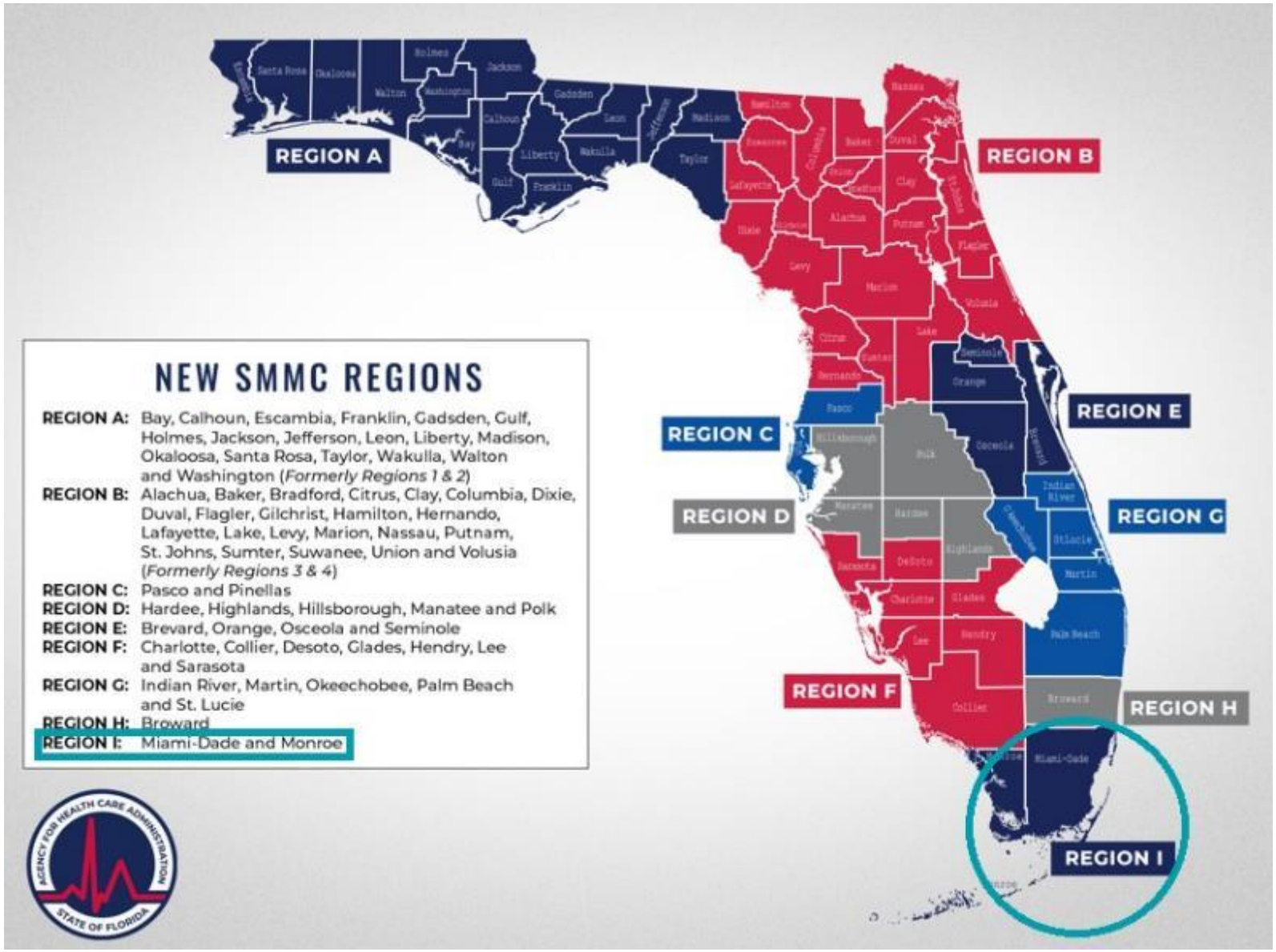
As a provider, you are essential to the success of our health plan and to delivering quality care to our members in these counties.

If there are significant updates to the provider orientation, we will make every effort to inform you in advance through our website, email, fax communications, and provider portal.

Molina Healthcare Plan Types



Molina Medicaid Service Regions



MOLINA HEALTHCARE | You Matter to Molina

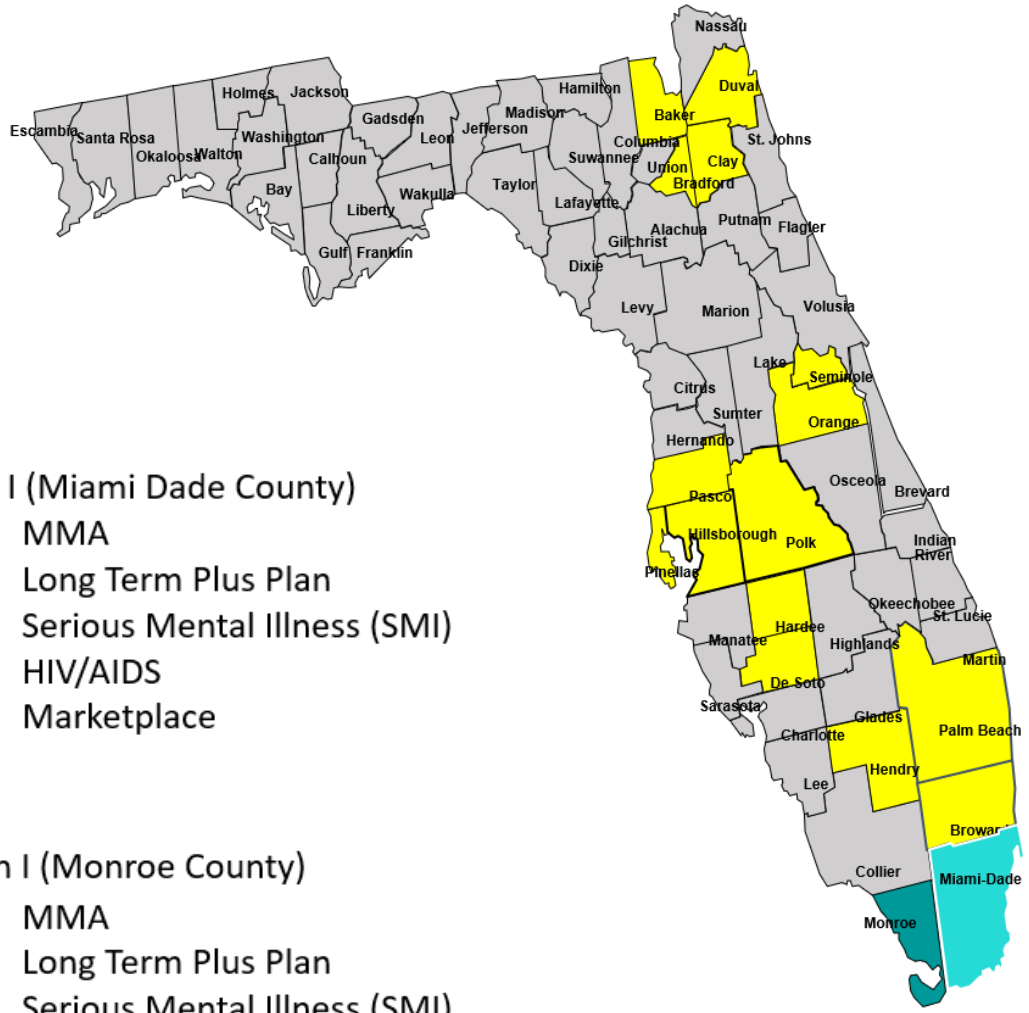
Product Service Areas

MMA/LTC:
- Miami Dade
- Monroe

SMI
- Miami Dade
- Monroe

HIV/AIDS
- Miami Dade
- Monroe

MP
- Baker
- Bradford
- Broward
- Desoto
- Duval
- Clay
- Hardee
- Hendry
- Hillsborough
- Miami-Dade
- Orange
- Pasco
- Palm Beach
- Pinellas
- Polk
- Seminole



– Region I (Miami Dade County)
- MMA
- Long Term Plus Plan
- Serious Mental Illness (SMI)
- HIV/AIDS
- Marketplace

– Region I (Monroe County)
- MMA
- Long Term Plus Plan
- Serious Mental Illness (SMI)
- HIV/AIDS

- Marketplace

*2/1/2025 Molina is operating in 17 Counties

*Effective 1/1/2024 The Health Plan exited the market for Medicare line of business

Molina FL Provider Services

Provider Services Department

The Provider Services department handles telephone and written inquiries from Providers regarding address and Tax-ID changes, contracting and training. The department has Provider Services representatives who serve all of Molina's Provider network. Eligibility verifications can be conducted at your convenience via the Availity Essentials portal.

Phone: (855) 322-4076
Fax: (866) 948-3537
Availity Essentials Portal: provider.MolinaHealthcare.com

For additional supportive provider resources, please visit our dedicated resource page: Molina Healthcare

If you need further assistance, don't hesitate to contact our support team directly for guidance.

Availity

Availity Essentials Portal Tools

Providers and third-party billers can use the no-cost Availity Essentials 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 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
- Referrals
  - Submit Specialist Referrals (PCPs Only)
  - Review referral status
- Download Forms and Documents
- Send/receive secure messages to/from Molina

Not registered with Availity?

Registering your organization is easy and free. Your organization's administrator should register at provider.MolinaHealthcare.com.

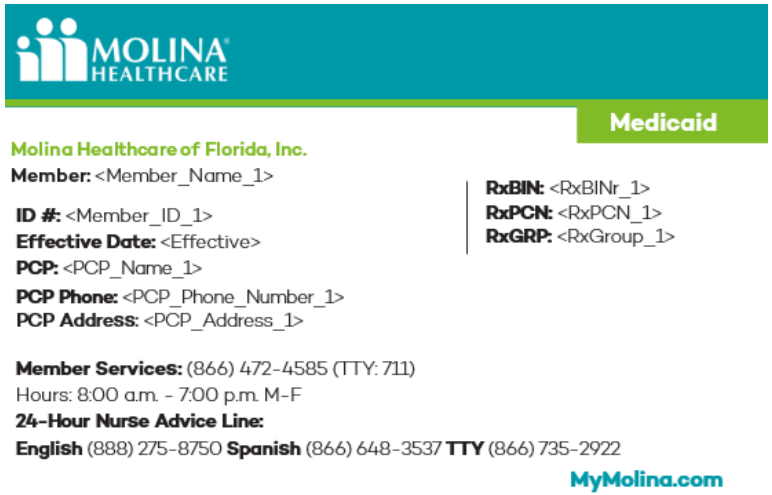
Getting started:

Once you are registered with Availity, ask your administrator for the eligibility and benefits, claims/claim status, medical attachments and messaging roles. You can always visit the Availity Learning Center for training opportunities. You can access training material from within the Availity portal by selecting Help & Training > Get Trained > Sessions.

Member Eligibility Verification

All Members enrolled with Molina Healthcare receive an identification card from Molina Healthcare in addition to the Florida Medicaid ID card. Molina Healthcare 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 Healthcare ID card and Florida Medicaid card) with them when requesting medical or pharmacy services.

Example:



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.

You may verify eligibility and PCP assignment through our Availity provider portal at https://availity.com/molinahealthcare or call Molina FL Provider Services at (855) 322-4076

Member Eligibility Verification (Continued)

Medicaid Recipients

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 http://mymedicaidflorida.com. When calling to verify a Member's eligibility, Providers will need their 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 can 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 eligibility information for a particular recipient and automatically faxes 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

Provider Handbook & Resources

Molina recognizes the importance of communication with its network providers and offers various tools and resources to ensure access to the most-up-to date Molina information. Providers may visit our website for member eligibility, claims status, or to download handbooks and forms. Hard copies of the Provider handbook are available to all providers, at no charge. Contact Provider Services for a copy.

Providers may also call Provider Services and speak with a representative who will address any questions or concerns:

Provider Services Toll-Free Line: (855) 322-4076
On the web: MolinaHealthcare.com

Transportation Services

Molina Healthcare offers its members access to transportation through Access2Care Transportation. To make an appointment for a transportation service, contact A2C Transportation's reservation line at:

- MMA/Specialty/LTC/HIV: 1(888) 298-4781 - 8am – 7pm ET

Translation Services

Molina Healthcare offers oral and written translation services to assist members in communicating with providers, Molina Member Services representatives, and case managers.

These services include:

- Oral and written translation services for members with low English proficiency
- Sign language interpretation services for the hearing-impaired
- Member materials in Spanish, French Creole, Vietnamese, Braille, or in audio format

Providers may request interpreter services for any Molina Healthcare Member at no cost to the provider or the Member.

If you require translation services for a Molina Member, please contact Member Services at (866)472-4585 or for the hearing impaired, 711, to make an appointment with a qualified interpreter.

Pharmacy

Molina's drug formulary 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 State (AHCA) 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.

Pharmacy Authorizations
Phone: 855-322-4076
Fax: 866-236-8531

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.

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 www.MolinaHealthcare.com or calling Molina at (855) 322-4076.

Molina Pharmacy Prior Authorization Form:
https://www.molinahealthcare.com/providers/fl/PDF/Medicaid/forms_FL_PARequestForm.pdf

Pharmacy (Continued)

Preferred Drug Lists

Molina covers those drugs and dosage forms listed in the formularies below for Marketplace:

Molina Marketplace Preferred Drug List (PDL):
www.molinamarketplace.com/marketplace/fl/en-us/-/media/Molina/PublicWebsite/PDF/members/fl/en-us/Marketplace/formulary-2021.pdf

In Office Labs

Molina's providers for laboratory services are Quest Diagnostics and LabCorp

Quest Diagnostics
866-MYQUEST (866-697-8378)
www.questdiagnostics.com

LabCorp
800-845-6167
www.labcorp.com

Molina allows only specific laboratory tests in the physician's office. All other medically necessary laboratory testing must be directed to Quest by the ordering physician.

For a list of approved in-office tests, visit Molina's website at www.molinahealthcare.com

This list includes most tests currently performed in the office by our network providers, and tests generally considered essential ("stat") for immediate diagnosis and treatment. Claims for tests performed in the physician office, but not on Molina's list of allowed in-office laboratory tests will be denied.

For more information about In-Network Laboratory Providers, please consult the Molina Provider Directory on our website.

For testing available through In-Network Laboratory Providers, or for a list of In-Network Laboratory Provider patient services centers, please reach out to the In-Network Laboratory Provider.

*Specimen collection is allowed in a 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.

Emergency Services

Emergency services are covered 24 hours a day, 7 days a week, 365 days a year for all Members experiencing an emergency medical situation.

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

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.

When a Member presents at a hospital seeking emergency services and care, the determination that an emergency medical condition exists shall be made, for the purposes of treatment, by a physician of the hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a hospital physician.

If member is being observed or admitted, an authorization is required

Emergency Room Alternatives

Although Molina provides coverage for emergency services, we kindly ask that you assist members in understanding the appropriate use of emergency rooms.

Different levels of care may effectively meet the member's medical needs. Some alternative options include:

- Participating Urgent Care Services
- Telehealth Services
- Molina Nurse Advice Line
  - English Phone: (888) 275-8750
  - Spanish Phone: (888) 648-3537

Urgent Care Services

Life-threatening situations require the immediate services of an emergency department.

A PCP should handle non-emergency conditions like sprains, strains, stomachaches, earaches, fevers, coughs, colds, and sore throats. If a member contacts you after hours about urgent care and you are unable to accommodate them, please refer them to an urgent care center.

Urgent care can offer prompt after-hours treatment and is suitable for conditions such as infections, fever, and symptoms of cold or flu.

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

Telehealth Services

You can access physical and behavioral health services through Participating Providers using Telehealth and Telemedicine.

Please note that not all Participating Providers offer these services.

For more details, please refer to the Telehealth and Telemedicine services section in the definitions. Additionally, the following provisions apply to the use of Telehealth and Telemedicine services:

Telehealth is done primarily online with internet access on your computer, tablet, or smartphone.

Common telehealth care options include:

- Lab test or x-ray results
- Therapy and online counseling
- Recurring conditions like migraines or urinary tract infections
- Skin conditions
- Prescription management
- Urgent care issues like colds, coughs, and stomach aches
- Post-surgical follow-up

Telehealth Provider Requirements

When delivering services through telemedicine, the Managed Care Plan will ensure that all providers offering Telehealth services adhere to the following requirements:

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.

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

Nurse Advice Line

This telephone-based nurse advice line is available to all Molina Healthcare 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 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)

Covered Services

For more information Molina's Covered Services and criteria, please refer to the Provider Handbook or contact Molina Healthcare.

Covered Services	
Advanced Registered Nurse Practitioner Services	Laboratory and Imaging Services
Ambulatory Surgical Treatment Center Services	Medical Supplies, Equipment, Prostheses and Orthoses
Behavioral Analysis	Nursing Care
Birthing Center Services	Optical Services and Supplies
Early Periodic Screening Diagnosis and Treatment Services for Recipients Under Age 21	Optometrists Services
Emergency Services	Physical, Occupational, Respiratory, and Speech Therapy
Family Planning Services and Supplies	Physician Services, including physician assistant services
Healthy Start Services	Podiatric Services
Hearing Services	Prescription Drugs
Home Health Agencies Services	Renal Dialysis Services
Hospice Services	Respiratory Equipment and Supplies
Hospital Inpatient Services	Substance Abuse Treatment Services
Hospital Outpatient Services	Transportation to Access Covered Services

Expanded Benefits

For more information Molina's Covered Services and criteria, please refer to the Provider Handbook or contact Molina Healthcare.

MMA	Specialty Plan	Pathways to Prosperity
Aging in Place Housing Assistance Grant	Acupuncture	Childcare Assistance
Ambulatory Detox Services	Assessment Services	Criminal Expungement
Chiropractic	Behavioral Health Day Services/Day Treatment	Food Assistance
Doula Services	Behavioral Health Screening Services	Housing Assistance
Hearing Services	Behavioral Health Medical Services (Verbal Interaction)	GED preparations course reimbursement
Home Delivered Meals – Disaster Preparedness/Relief	Behavioral Health Medical Services (Medication Management)	Non – Medical Transportation
Home Delivered Meals – Post – Facility Discharge (Hospital or Nursing Facility)	Behavioral Health Medical Services (Drug Screening)	Specialty Plan Housing
Home-delivered meals-Chronic Conditions	Collaborative Care	
Life Skills Development	Medication Assisted Treatment	
Nutritional Counseling	Psychosocial Rehabilitation	
Pet Support	Substance Abuse Treatment or Detoxification Services (Outpatient)	
Physical Therapy	Therapy Massage	
Prenatal Services	Mental Health Targeted Case Management	
Occupational Therapy		
Speech Therapy		
Respiratory Therapy		
Service/Therapy Animal Benefit		
Behavioral Health Therapy/Psychotherapy (Group)		
Behavioral Health Therapy/Psychotherapy (Individual, Family)		
Vision Services		

In Lieu of Services

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.

MMA & Specialty Plan
Addictions Receiving Facility Services
Ambulatory Detoxification Services
Community Based Wrap-Around Services
Crisis Stabilization Unit Services
Drop-In Center Services
Family Training and Counseling for Child Development
Functional Family
Housing Assistance
Infant Mental Health Pre and Post testing Services
Inpatient Detoxification or Addiction Receiving Facility Services licensed under s.397, f.s.
Mental Health Intensive Outpatient Program Services
Mental Health Partial Hospitalization Program Services
Mobile Crisis Assessment and Intervention Services
Multisystemic Therapy Services
Nursing Facility Services
Partial Hospitalization Services
Psychiatric Specialty Hospital Services
Self Help/Peer Services
Substance Abuse Intensive Outpatient Program Services
Substance Abuse Short-term Residential Treatment Services

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

Behavioral Health Services

Members needing access to Behavioral Services can be referred by their PCP or self-refer by calling Molina's Behavioral Health Department at (855) 322-4076. Molina's Nurse Advice Line is also available 24/7 for mental health or substance abuse needs. All services provided will be confidential.

For more information on Covered Services, any limitations, and details about inpatient services and cost shares, please visit: Molina Healthcare or contact Molina directly. If inpatient services are required, prior authorization must be obtained unless it's an emergency situation.

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, plans will be made to transfer Members to an in-network facility when Member is stable.

Substance Abuse Services

Physicians must be familiar with the signs and symptoms of abuse to make the diagnosis and provide therapies for acute intoxication and withdrawal along with resources for long-term treatment. Although many of the signs and symptoms of substance abuse can be caused by other diseases, the differential diagnosis should include drug abuse. PCPs are required to screen members for signs of substance abuse as part of preventative evaluation at the following times:

- Initial contact with a new enrollee;
- Routine physical examinations;
- Initial prenatal contact;
- When the Member evidences serious over-utilization of medical, surgical, trauma or emergency services; and when documentation of emergency room visits suggests the need.

The Behavioral Health Toolkit for Providers was designed to offer guidance regarding mental health and substance use conditions commonly seen in the primary care and community setting.

Assessment and Diagnosis of Behavioral Health Conditions in the Primary Care Setting including:

- Depression
- Suicidality
- Substance Use Disorders (Alcohol and Other Drugs) and Opioid Use Disorders
- Anxiety
- Dementia and Alzheimer's
- Attention Deficit/Hyperactivity Disorder (ADHD)

Substance Abuse Toolkit (molinahealthcare.com)

Behavioral Toolkit (molinahealthcare.com)

Substance Abuse Services

What 24/7 crisis support services are available to members?

- Molina offers 24/7 Telehealth crisis intervention services in partnership with Impower. MMA and SMI members can call (689) 688-9875 to speak with a clinician who will send the member a link to begin a virtual telehealth session.

How are referrals made to BH providers?

- BH referrals do not require a PCP referral. To locate a participating BH provider, use the provider directory at: MFL Provider Directory or call into our Member Call Center **866-472-4585**

How are referrals made to case management and social service programs?

- Maternity: MFLCaseManagement@MolinaHealthCare.Com
- Non-Maternity: MFL-SP@MolinaHealthCare.Com

Screening, Brief Intervention, & Referral To Treatment

Substance Abuse and Mental Health Services Administration (SAMHSA) SBIRT codes have been added to the Medicaid Practitioner Fee Schedule. The codes are applicable to fee-for-service and managed care. At this time, only physicians and physician extenders can render SBIRT services. This includes the following provider types:

25 – M.D. 26 – D.O. 29 – PA 30 – APRN

Code	Description
H0049	Alcohol and/or drug screening
H0050	Alcohol and/or drug screening, brief intervention, per 15 minutes

Procedure Codes

H0049 can be used once per day, as medically necessary and is not limited by age. H0050 is allowed for 0-4 units per day, as medically necessary, and is not limited by age.

The place of service is open for office visits, telehealth, all hospital settings and clinics, and ambulatory surgical centers.

The new SBIRT codes are intended to be used in primary care and other medical settings. These services may be performed and billed in addition to an Evaluation and Management (E&M) service when provided during the same visit.

Behavioral Health Online Screening Tools

Online screening tools that are available

Molina endorses the use of the PHQ-9 (Patient Health Questionnaire 9 Questions), a standardized depression screening tool with established clinical validity. The PHQ-9 screening tool, scoring instructions and description of depression risk levels (low/maintenance level; moderate; high/severe) can be found on the SAMHSA website at https://www.integration.samhsa.gov/clinical-practice/screening-tools

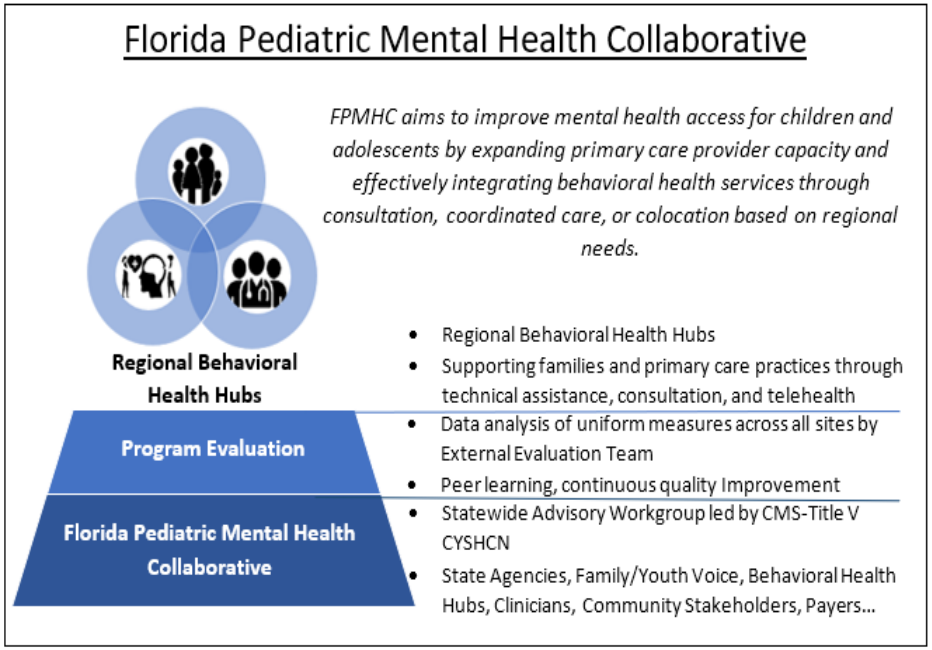
BH Toolkit - Depression Screening and Follow-up (molinahealthcare.com)

SBIRT is Screening, Brief, Intervention, and Referral to Treatment. Molina promotes the use of the CAGE-AID to screen for alcohol and other drug abuse & dependence. You can obtain a copy of the CAGE-AID, as well as background and metrics directly on the SAMHSA website at https://www.integration.samhsa.gov/images/res/CAGEAID.pdf. The CAGE-AID questionnaire is used to test for alcohol and other drug abuse and dependence in adults. The tool is not diagnostic but is indicative of the existence of an alcohol or other drug problem.

Behavioral Toolkit - Assessment and Interventions for Substance Use and Opioid Use Disorders

Florida Pediatric Mental Health Collaborative (FPMHC)

- The Florida Department of Health's Title V program has collaborated with partners to develop a statewide behavioral health network, the Florida Pediatric Mental Health Collaborative.
- The FPMHC is the organizing body for regional behavioral health hubs (BHH).
  - Each regional BHH has implemented an evidenced-based model of IBH that best meets their community needs.
  - BHHs work with local primary care pediatric providers to build the providers' capacity in mental health diagnoses, treatment, and referral of children with mental/behavioral health conditions.
  - This work includes a needs assessment process, tailored skills building training, technical assistance, evidenced-based treatment, and telehealth consultations.
  - Each BHH also establishes a referral network of local behavioral health providers to address the range of treatment needs a child or youth may have.



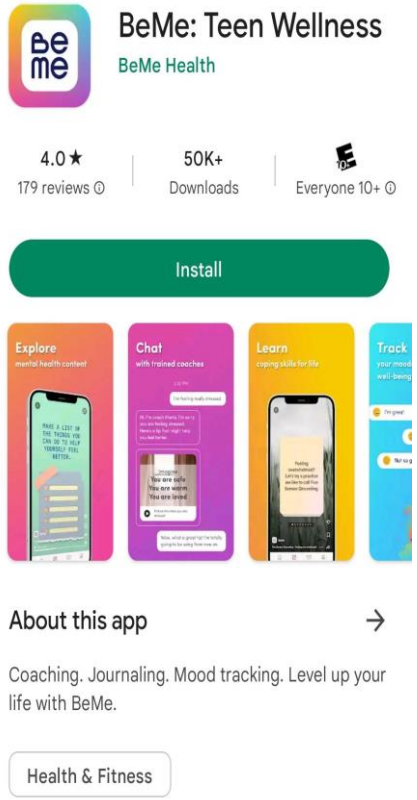
Behavioral Health and Related Topics | Florida Department of Health (floridahealth.gov)

FPMHC: Regional Behavioral Health Hubs Contact Information

University of South Florida: Florida Center for Behavioral Health Improvements and Solutions	Florida State University's College of Medicine Center for Behavioral Health Integration and Tallahassee Pediatric Behavioral Health Center	University of Florida's Dept of Psychiatry, Division of Child & Adolescent Psychiatry	University of Miami's Miller School of Medicine Department of Psychiatry and Behavioral Sciences	Florida International University's Herbert Wertheim College of Medicine Department of Psychiatry and Behavioral Health
13301 Bruce B. Downs Blvd. MHC 2723 Tampa, Florida 33612	1126 Lee Avenue, Tallahassee Florida 32303 1115 West Call Street Tallahassee, FL 32306	Springhill Health Center II | 4197 NW 86th Terrace | Gainesville, FL 32606 Creekside Psychiatric Center | 5190 Bayou Blvd, #6 | Pensacola, FL 32503	1800 NW 10th Ave, Miami, FL 33136	11200 SW 8th Street, AHC1-348 Miami, FL 33199 Tel: 305-348-4147
Contact: Sabrina Singh at sabrinasingh@usf.edu.	Contact: Heather Flynn, Ph.D Phone: (850) 645-7367 heather.flynn@med.fsu.edu	Contact: Gainesville Hub PSYCH-UFBHH@ad.ufl.edu Phone: 352-265-2252 Contact: Panhandle Hub UFBHH_PNS@creeksidepa.com phone: 850-476-0977	Contact: Phone 305-243-9905 or 305-243-0214	Contact: Kathy Palacios kapalaci@fiu.edu Phone: 305-348-7502
Tampa	Tallahassee	Gainesville and Pensacola	Miami	Miami
https://floridabhcenter.org/	https://wholechildleon.org/bhnavigation/ https://med.fsu.edu/behavioralhealthintegration/home	https://bhh.psychiatry.ufl.edu/	https://med.miami.edu/departments/psychiatry/divisions-and-programs/child-and-adolescent-psychiatry	https://medicine.fiu.edu/about/departments/psychiatry-and-behavioral-health/clinical-services/clinical-service-contracts/index.html

The Florida Behavioral Health Collaborative Pediatric Hotline: 1-866-487-9507

Member Resources: BeMe App



What is BeMe?

A mental health digital app designed for teenagers.

Available at no cost to all Molina Members ages 13-19.

- Help teenagers manage big feelings and challenges
- Diverse and educational content, coping & resilience skill-based activities, one-on-one human coaching
- Clinical screenings and triage, connections to clinical services, 24/7 crisis support & safety planning

How to refer a teen?

Referrals could not be easier!

- Advise the teen to use their mobile phone to scan the QR code
- or download the app from the link below
- Molina BeMe Register Link
- If the teen is not available, advise parent/guardian to provide info to their teen
  - Download app
    - For teen sign up
    - Build their profile
    - Support will be available

MOLINA HEALTHCARE

You Matter to Molina

Member Resources: Pyx Health App

- The Pyx Health app is a digital tool for Molina members 18 years and older, addressing loneliness and isolation
- Members who experience loneliness, anxiety, or depression and/or are socially isolated benefit most from the program
- Pyx Health combines technology (Pyxir- the Pyx Health chatbot) and live support from the Compassionate Care Center (CSC) providing
  - Engaging, interactive content and games, including Molina Healthcare phone numbers and information
  - CSC staff for companionship and resource referrals
  - Regular check-ins to track feelings and self-management tips supporting physical and mental health needs
  - Social Determinants of Health screenings to direct members to resources
- Provider referrals for members can be sent via email with member's name and date of birth to: support@pyxhealth.com
- Members can enroll or register by searching "Pyx Health" in the Apple App Store or Google Play store, calling Pyx Health directly at 855-499-4777 (option 1) or the following link: https://hipyx.com/account/signup

Psych Hub: Comprehensive Platform for Mental Health Education

Psych Hub is available to all Molina Providers

- It is an online platform for digital mental health education
- Providers can access Psych Hub's free micro-video library containing over 180+ consumer-facing, animated videos
- The videos focus on improving mental health literacy and reducing stigma on seeking behavioral health care
- Videos are available with subtitles in English, Spanish, French and Portuguese
- Registration and access is easy
    - Visit https://app.psychhub.com/signup/molina-mhp/
    - Select "MENTAL HEALTH PRACTITIONER HUB" to create a profile
    - Search and take courses of interest

Behavioral Health Resources

What telehealth services are available to members?

Provider Contact
www.teladoc.com 800-835-2362
Brave Health - Specialists in behavioral health (bebravehealth.com) 305-902-6347

BH referrals do not require a PCP referral.

- To locate a participating BH provider, use the provider directory
- Call into our Member Call Center **866-472-4585**

How are referrals made to case management and social service programs at Molina?

- Maternity: MFLCaseManagement@MolinaHealthCare.Com
- Non-Maternity: MFL-SP@MolinaHealthCare.Com

Please refer to our provider directory for our network of behavioral health/substance abuse specialists

Covered LTC Plan Services

Under the Statewide Medicaid Managed Care Long-term Care (LTC) program, managed care plans (LTC plans) are required to provide an array of home and community-based services that enable enrollees to live in the community and to avoid institutionalization.

When meeting the member's assessed needs it is important for the case manager to know:

- What covered services are available
- How the services are used
- When to authorize the services

These services are typically offered in an assisted living facility and may include housekeeping, assistance with bathing, dressing, and eating, medication support, and social programs. Please note that prior authorization is required for these services.

LTC Covered Services

Adult companion care	Hospice
Adult day health	Intermittent and skilled nursing
Assisted living	Medical equipment and supplies
Assistive care services	Medication administration
Attendant Nursing care	Medication management
Behavioral management	Nursing facility services
Care coordination/Case Management	Nutritional assessment/Risk reduction
Caregiver training	Personal care
Home accessibility adaptation services	Personal emergency response system
Home delivered meals	Respite care
Homemaker Services	Therapies (OT, PT, RT, ST)
Transportation, non emergency	

Skilled Nursing Facility Coverage

- **As in Lieu of Hospital Services :**

Molina Healthcare will review all requests of Skilled Nursing Facility as in lieu of Hospital Care and approve such services based on Medical Necessity.

- **Long Term Care Members: Custodial Care**

- **Enrollees under eighteen (18)years old**

- **Enrollees ages eighteen (18) years of age and older in the following circumstances:**

For up to one-hundred twenty (120) days from the date of the most recent nursing facility admission, regardless of payer.

- Molina requires Skilled Nursing Facilities to submit a Notification of admission within 7 calendar days of admission. Upon notification, Molina assigned a Care Coordinator to assist with the ICP process and CARES referral.

- Molina Healthcare will approve Skilled Nursing Facility services when the PASRR requirements have been met and the facility submits an update related to the ICP application. The Skilled Nursing Facility is required to collaborate with Care Coordinator to ensure timely and complete submission of the CARES referral packet for LTC transition.

Coastal Care Services

Home Health, Home Infusion, Durable Medical Equipment (DME)

Coastal Care Services manages, credentials, and pays claims for DME, Home Health, and Home Infusion services for Molina's Medicaid(MMA Only and Specialty Plan only) and Marketplace members.

- Claims should be **sent directly to Coastal Care Services**. Any claims for the above services will be denied by Molina and redirected to Coastal Care Services.
- Please ensure that all services requested adhere to Molina's prior authorization guidelines.
- For Home Infusion services information, please contact Coastal Care Services at: (855) 481-0505.

*Coastal Care Services is not used for members in the Medicaid Comprehensive plans: MMA & LTC Comprehensive, or Specialty Plan & LTC Comprehensive. For these members contact Molina Healthcare (866)-440-9791

Doula Services

Doula Services are provided by a professional trained in childbirth who can provide emotional, physical, and educational support to a mother who is expecting, is experiencing labor, or has recently given birth. The doula's purpose is to help women have a safe, memorable, and empowering birthing experience.

Molina Healthcare covers doula services as an expanded benefit for Managed Medical Assistance (MMA), Specialty, and Comprehensive (MMA/LTC) members.

Please review the Doula Benefits Grid and Procedure Codes found under **Billing Guidelines** on our website: https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/fl/medicaid/Doula-Billing-and-Reimbursement-Guidelines-FINAL-092122_R.pdf

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.

American Therapy Administrators of Florida/Health Network One (ATA-FL/HN1)

Physical, Speech, and Occupational Therapy

Molina Healthcare of Florida partners with American Therapy Administrators of Florida/Health Network One (ATA-FL/HN1) as its therapy vendor.

- Contact Number: 1.888.550.8800
- Fax Number: 305-620-5973

Email: ATAFL@healthnetworkone.com

All services other than initial evaluations will require prior authorization and providers will be required to follow ATA-FL's Prior Authorization process.

Authorizations may be requested via:

- **Fax:** 1-855-410-0121
- **Phone:** 1-888-550-8800
- **Secure Portal**: asp.healthsystemone.com/pwprequestform/?id=ataflorida

*Excludes Early Interventions Services

Note: PT/OT/ST services for LTC only members will be managed directly through Molina.

Progeny

Progeny Health is a delegated vendor for Utilization Management. Effective 09/01/2022, Progeny Health will conduct all initial/concurrent review and Authorization for NICU admissions for Molina Healthcare of Florida Members. Progeny will also offer 60 days of Case Management activities post discharge for members managed by them.

Progeny Health's regular hours of operation are 8:30 am to 5:00 pm Monday through Friday EST.

You will notify Progeny Health via phone or fax

Utilization Management: Call 888-832-2006 and select option 3

Utilization Management Secure Fax Number: 866-879-0331This dedicated fax number will be provided by Progeny Health

Case Management: Call 888-832-2006 and select option 4

Case Management Secure Fax Number: 855-834-2567

Evolent

Evolent performs Utilization Management services on behalf of Molina Healthcare for outpatient oncology, Cardiology and Radiology Oncology . If your request is for a member over 21 years of age with a cancer diagnosis, please submit your Prior Authorization request directly to New Century Health via their provider portal at https://my.newcenturyhealth.com/ or you may call New Century Health at 1-888-999-7713. Approval of services by New Century Health does not guarantee payment. Payment is dependent on member eligibility at the time of service, benefit coverage and limitations, provider agreements, and submission of accurate claims.

Radiology Services

Prior Authorization Requirements

Routine imaging such as X-Rays do not require Prior Authorization*

Imaging such as CT, MRI, MRA, PET, SPECT require Prior Authorization*

Diagnostic procedures are covered when the member is inpatient in the hospital

ALL Elective Services in a Hospital setting will require Prior Authorization.

Some services require Prior Authorization

For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal.

Refer to the Prior Authorization Code Lookup Tool on our website for requirem
MolinaHealthcare.com/providers/fl/medicaid/home.aspx

MOLINA HEALTHCARE | You Matter to Molina

MCG Auto Auth

Radiology Services

Molina has partnered with MCG Health to introduce Cite for Guideline Transparency, which providers can access through the Availity Essentials portal. This tool allows Molina to share clinical indications with providers as a secure extension of our existing MCG investment, helping to meet regulatory transparency requirements for care delivery. Self-service options available in the Cite AutoAuth tool include, but are not limited to, MRIs, CTs, and PET scans. For a complete list of imaging codes that require prior authorization, please refer to the PA Code Look-Up Tool at MolinaHealthcare.com

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.

*Cite AutoAuth can be accessed via the Availity Essentials portal and is available 24 hours per day/7 days per week. This method of submission is strongly encouraged as your primary submission route, existing fax/phone/email processes will also be available.

Case Management Services

The Member's PCP leads the health team, coordinating and directing the services for the Member, and is responsible for preventive and primary medical care. The case manager supports the PCP by providing the Member's individualized care plan (ICP), updates from the interdisciplinary care team (ICT), and progress information as needed. Together, the care manager and the Member, along with any authorized representatives, develop and implement the ICP, which includes medical and psychosocial interventions, care coordination, health education, and expected outcomes.

- 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.

The following conditions may qualify a Member for case management:

- 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.)
- Member accessing emergency department services inappropriately
- Children with Special Health Care Needs
- Home Health Care

Contact us to make a Case Management referral

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

Specialty Plan

This is a Medicaid specialty plan and is part of the Statewide Medicaid Managed Care program specializing in the care of those with Serious Mental Illness (SMI).

Eligibility Criteria:

- ✓ Member must be eligible for Medicaid and have been diagnosed with a serious mental illness.
- ✓ Member must be age 6 or older
- ✓ Member must be in Region I (Miami Dade & Monroe counties)
- ✓ Member must be diagnosed with Schizophrenia, Schizoaffective Disorder, Delusional Disorder, Bipolar Disorder, Major Depression or Obsessive-Compulsive Disorder (OCD) and be treated with a medication commonly used to treat the disorder.

Specialty Plan members receive MFL ID cards reflecting “Specialty Plan A”.

Behavioral Analysis

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.

Please refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.

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.

Prior Authorization Requests

Molina requires prior authorization for certain services to comply with Federal and State regulations, as well as the Molina Hospital or Provider Services Agreement. You can find a narrative and detailed list of these services, including CPT and HCPCS codes. While Molina generally updates prior authorization documents quarterly, they may be updated more often if needed, and you can access them on the Molina website at:

Medicaid:

Molina Healthcare MCD 2023 PA Guide

Marketplace:

https://www.molinahealthcare.com/providers/fl/marketplace/forms/Pages/fuf.aspx

Service Request Forms may be faxed to the Utilization Management Department to the numbers listed below or submitted via the Provider Availity Portal.

Medicaid/Marketplace Fax: (866)-440-9791

Prior Authorization Requests (Continued)

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 prior authorization may not be eligible for payment. Emergency services, as defined by Federal and State law, are exempt from prior authorization requirements. Authorization does not guarantee payment, as Molina reserves the right to review benefit limitations and exclusions, verify beneficiary eligibility on the date of service, ensure correct coding and billing practices, and assess if the service was provided in the most appropriate and cost-effective setting. Additionally, Molina does not retroactively authorize services requiring prior authorization.

Prior Authorization Requests (Continued)

Urgent vs Non-Urgent Requests

Urgency is reserved for those tests required to prevent serious deterioration in the member's health or ability to regain maximum function. Urgent status may also be appropriate if, in the opinion of the ordering provider with knowledge of the member's medical condition, delay would subject the member to severe pain that cannot be adequately managed without the care or treatment being requested.

Requests outside of this definition should be submitted as routine/non-urgent.

Molina Healthcare of Florida will process all “non-urgent” requests in no more than 7 calendar days of the initial request. “Urgent” requests will be processed within 72 hours of the initial request.

Providers who request prior authorization approval for patient services and/or procedures can request to review the criteria used to make the final decision.

Providers may request to speak to the Medical Director who made the determination to approve or deny the service request.

Prior Authorization Requests (Continued)

Supporting Documentation

Molina Healthcare requires prior authorization for all elective services rendered in a hospital setting for all lines of business. Authorization for elective services should be requested with supporting clinical documentation at least 7 days prior to the date of the requested service.

Authorization for emergent services should be requested within 1 business day.

Information generally required to support decision making includes:

- ✓ Current (up to 6 months), adequate patient history related to the requested services
- ✓ Physical examination that addresses the problem
- ✓ Lab or radiology results to support the request (Including previous MRI, CT, Lab or X-ray report/results)
- ✓ PCP or Specialist progress notes, consultations and/or Plan of Care (PoC)
- ✓ Any other information or data specific to the request

All chart notes relevant to the prescription request **must** be submitted along with the completed Prior Authorization form to avoid delays in processing due to insufficient information or lack thereof.

Please Note: If you receive an Authorization request denial for "*no chart notes submitted*", please attempt to resubmit your request instead of submitting an appeal, as proper clinical review did not take place.

Continuity of Care

Molina is committed to giving Members advance notice when a Provider they are seeing will no longer be in-network. During this period, Members and Providers are encouraged to transition care to an in-network Provider. The departing Provider will ensure that all relevant information about the course of treatment and medical care is shared with the new Provider(s) taking over the care.

Molina will inform Members in active care at least 120 days prior to a provider's termination date and will allow them to continue receiving services from the provider for at least 120 days following the termination. However, the continuation of care cannot extend beyond six months after the provider's termination date.

Molina Members undergoing an active course of treatment have the option to complete their treatment with the Provider who started their care for the first 120 calendar days from the date of enrollment. This option remains available regardless of whether the Provider has a current contract with Molina or if a contract has been terminated.

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

Continuity of Care (Continued)

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.

Continuity of Care for SMI Members

Members in active treatment will continue receiving care from their current provider for the first 120 calendar days under our plan. After this period, Molina will collaborate with the member and the non-participating provider to decide on the continuation of care, authorizing it only in special cases, while the Member Services department can help find a participating provider if needed.

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.

Encounter Data

All providers, including capitated Providers or organizations delegated for claims processing, must submit encounter data to Molina for all adjudicated claims. This data supports various functions, including regulatory reporting, rate setting, risk adjustment, hospital rate setting, the Quality Improvement program, and HEDIS® reporting.

Encounter data must be submitted **at least once per month, and no later than seven (7) days** following the date on which Molina adjudicates the claims in order to meet State and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including:

- ANSI X12N 837I – Institutional,
- 837P – Professional, and
- 837D -- Dental

Providers must correct and resubmit any encounters which are rejected (non-HIPAA compliant) or denied by Molina. Encounters must be corrected and resubmitted within **fifteen (15)** days from the rejection/denial.

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.

Claims

Claims Submission

Providers may submit claims to Molina Healthcare on paper or electronically, using a current version CMS-1500/UB-04 or the electronic equivalent. Providers may also use our Availity Portal to submit claims.

Providers can register with SSI Claimsnet, LLC for claim submission via the Claimsnet's Provider Registration Form located online at: https://products3.ssigroup.com/ProviderRegistration/register

Marketplace/Medicaid/LTC Claims Submission Address
Molina Healthcare of Florida
P.O. Box 22812
Long Beach, CA 90801

EDI Claims Submission – All LOB's
Payor ID# 51062

Availity Portal
https://www.availity.com/molinahealthcare

Claims (Continued)

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 **6 months** after receipt of Clean Claims.

The receipt date of a Claim is the date Molina receives notice of the Claim.

Claims (Continued)

Timely Filing

F.S. 641.3155 requires that Participating providers submit all claims within six (6) months of the date of service. Network providers must make every effort to submit claims for payment in a timely manner, and within the statutory requirement.

Corrected Claims may be submitted at any time during the timely filing period of the provider contract.

Claims - Durable Medical Equipment (DME)

Billing Guidelines

All DME, medical supplies must be:

- Medically necessary, and
- Functionally appropriate for the individual recipient, and
- Adequate for the intended medical purpose, and
- For conventional use, and
- For the exclusive use of the recipient

DME items requested or supplied must not duplicate or perform the same function as other durable medical equipment or medical supplies currently in the recipient's possession.

Medical necessity documentation must specify the type, quantity, and frequency of need for consumable medical supplies prescribed by the recipient's treating physician or the treating physician's prescribing ARNP or Physician Assistant.

Claims - Home Health Services

Billing Guidelines

- ✓ Remember to bill in accordance with HCPCS description
- ✓ Units billed must be the total time for the Dates of Service
- ✓ Home Health agencies must bill for services on a daily basis.
- ✓ Dates of service may not span over various days.

Claims – Coastal

Molina is contracted with Coastal Care Services to provide Home Health, Home Infusion, and DME services for our MMA only and Specialty Members.

Address:

Coastal Care Services, Inc.
Attn: Claims Department
1200 NW 78th Ave.
Suite 100
Doral, FL 33126

Phone: (855) 481-0505

Note: Home Health, Home Infusion and DME services for LTC and Comprehensive (MMA & LTC) members will be managed directly through Molina.

Electronic Visit Verification (EVV)

The purpose behind the EVV mandate is to track home health providers and ensure the visits they're reporting to CMS are actually taking place, that patients are getting the care they require, and that Medicaid is being accurately billed.

Electronic Visit Verification (EVV) electronically captures:

- That a home care agency employee provided the agreed-upon point-of-care service
- The time that a visit began and ended
- The individual who received the service
- The date and location of the provided service

Other benefits of EVV technology solutions include the ability to:

- Reduce missed visits and late starts
- Improve patient care and client outcomes
- Reduce paper documentation traditionally associated with visit verification
- Increase productivity and efficiency among staff members
- Reduce costs associated with the use of multiple software products

Claims - EVV

Molina has partnered with HHAeXchange as our EVV vendor.

Molina requires providers to use HHAeXchange to submit confirmed visits and bill directly to HHAeXchange through the free HHAeXchange Portal.

HHAeXchange Portal: https://app.hhaexchange.com/hhax/Login.aspx

Providers must register for HHAX's portal by completing a Provider Portal Questionnaire located at: https://hhaexchange.com/fl-provider-reg

HHAeXchange Portal Functionality:

- Accept service authorizations within the portal
- Clock in and out in real-time using EVV mobile devices
- Timesheet is automatically created based on clocking in and out

***Long-Term Care (LTC) Home Health and Personal Care providers are required to use EVV**.

Claims – EVV HHAeXchange

EVV VERIFICATION REQUIREMENTS REMINDER

In accordance with CMS regulations, the delivery of all home health services to Medicaid recipients must be electronically verified via HHAeXchange, Molina Healthcare of Florida's (Molina) designated EVV vendor. This includes the requirement that providers use the vendor's mobile application and that GPS functionality be enabled on a provider's Smartphone, to fully comply with utilizing the mobile application for clocking in and out at the beginning and end of each home health service (home health visits, private duty nursing, and personal care services) encounter.

Effective July 1, 2024, all manually submitted home health claims will be denied.

Frequently Asked Questions

Q. How will the denial appear on the provider's Explanation of Payment (EOP)?

A.

REMIT ID	*REMIT MESSAGE*
N821	*Electronic Visit Verification System visit not found.*

Q. Once the claim has been denied, can I appeal?

A. The provider always has the right to appeal any claim determination, as indicated in the Explanation of Payment (EOP). Provider should ensure to include clinical documentation evidencing that the visit was completed, the dates/times and any extenuating circumstances for why EVV did not occur as required.

Q. Are there any allowed exceptions?

A. 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.

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

Claims - Assisted Living Services

These services are typically offered in an assisted living facility and may include housekeeping, assistance with bathing, dressing, and eating, medication support, and social programs. Please note that prior authorization is required for these services.

Molina Healthcare of Florida currently oversees, and processes claims for Assisted Living Facilities services under the Long-Term Care and Comprehensive (MMA & LTC) products.

You may mail the claims to:

Molina Healthcare of Florida

PO BOX 22812

Long Beach, CA 90801

or you can register to the provider portal for electronic claim submissions. You can register in the Availity Portal at: https://www.availity.com/molinahealthcare

For the Assisted Living Training and Billing guidelines, please visit our provider resource and training section at Resources & Training (molinahealthcare.com)

**All services requested must adhere to Molina's Prior Authorization guidelines.*

Claims - Assisted Living Services (Continued)

Assisted Living Facility Billable Codes

An Assisted living facility (ALF) is designed to provide personal care services in the least restrictive and most home-like environment. ALF services include personal care services, homemaker, chore, attendant care, companion care, medication oversight, and periodic nursing evaluations

Assisted Living Facility Billing Codes:

The Following codes are included below to assist you in billing for ALF services provided. Please refer to your contract with Molina Health Care in order to determine your contracted and covered codes.

Billing Codes:

Procedure Code	Description	Date Span Example	# Of Units
T2030	Assisted Living Services/Month	3/1/23 – 3/1/23	1
T2031	Assisted Living Services/Per Day	3/15-23 – 3/31/23	17
T2033	Bed Hold Days	3/15/23 – 3/28/23	14

Claims - Skilled Nursing Facility (SNF)

Billing Guidelines

SNF's should bill in accordance with Florida Medicaid guidelines

Billed Days	Revenue Code
Long Term Care Days	0101
Hospital Leave Days	0185
Home Leave Days (Therapeutic Bed Hold Days)	0182

Claims - iCare

Molina is contracted with iCare Solutions to provide routine vision services for our members. Members who are eligible may directly access a vision care network Provider.

Address:

iCare Solutions
Attn: Claims
7600 Corporate Center Dr
Suite: 200
Miami, FL 33126

Phone: (855) 373-7627

Electronic Claims Submission

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 Essentials 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 Essentials 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.

The Availity Essentials portal offers benefits for claims submission, including the ability to:

- Ability to add attachments to Claims
- Submit corrected Claims
- Easily and quickly void Claims
- Check Claims status
- Receive timely notification of a change in status for a particular Claim
- Ability to Save incomplete/un-submitted Claims
- Create/Manage Claim Templates

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

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.

The provider agrees to accept payment from Molina as payment in full or bill the appropriate responsible party. Provider may not bill a Molina Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:

- The Member has been advised by the Provider that the service is not a covered benefit and the Provider has documentation.
- The Member has been advised by the Provider that he/she is not contracted with Molina and has documentation.

The Member agrees in writing to have the service provided with full knowledge that they are financially responsible for payment.

Provider Disputes and Appeals

Any disagreement regarding the processing, payment or non-payment of a claim is considered a Provider Dispute. To file a provider dispute, providers may contact Customer Service at (855) 322-4076, or send the request for review in writing, along with any supporting documentation to:

Molina Healthcare of Florida
Appeal and Grievance Unit
P.O Box 36030
Louisville, KY 40233-6030
Fax: 877-553-6504

Provider disputes must be received within one (1) year of the date of payment or denial of the claim. All provider disputes will be reviewed confidentially, and the outcome will be communicated in writing within sixty (60) days or receipt of the provider dispute.

Provider Disputes and Appeals – Quick Tips

Disputes (Underpayments, Bundling)

Claim disputes are typically disputes related to overpayment, underpayments, untimely filing, missing documents (i.e. consent forms, primary carrier explanation of benefits) and bundling issues.

- Overpayment & Underpayments are based on the individual contract and/or Medicaid Fee Schedules
- Disputes can be submitted via phone, fax, provider portal, or by mail.
- Our Molina provider portal is our preferred method of delivery. It's important that all supporting documents are included.

Disputes impacting more than 10 claims can be submitted via email to:
MFLClaimsDisputesProjects@MolinaHealthCare.com

Appeals (Authorization, Medical Necessity)

- Appeals are those related to denial of authorization.
- Appeals can only be submitted in writing (fax, email, mail) or in-person.
- Our Molina provider portal is our preferred method of delivery. Its important that all supporting documents are included

Appeals can be submitted via email to:
MFL_ProviderAppeals@MolinaHealthCare.com

CD Format are always preferred, in order, to reduce large printing and cost of shipping.

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. Providers may request a review of their original appeal by the State's independent dispute resolution organization:

Capitol Bridge
Email Submissions to: FLCDR@capitolbridge.com
Tel: (800) 889-0549

Quick Facts

- Must be received within (1) year of payment or denial
- Disputes/Appeals shall be resolved within 60 days
- Provider Disputes/Appeals Fax (877)553-6504
- Provider Toll-Free Number (855)322-4076
- New and Corrected Claims* mail to:

P.O. Box 22812
Long Beach, CA 90801

*A corrected claim is not a dispute or an appeal.

Disputes and Appeals Documentation Requirements

Disputes/Appeals Documentation Requirements, including Claims Projects (10 or more affected claims), are as follows:

- Member Name
- Member ID
- Date of Service
- Billed Charges
- Amount Molina has paid
- Account Balance
- Rendering Provider, NPI and Tax ID
- Pay to Group, NPI and Tax ID
- Service code or CPT code
- Comments or category from the provider
- Line of Business
- Claim Number

To avoid delays in processing, all claim disputes/appeals must include supporting documentation (i.e. Proof of Timely Filing, Explanation of Benefits from Primary Carrier (COB Claims), Invoices, Medical Notes, Consent Forms, etc.

Provider Directory

Provider Data Accuracy and Validation

Providers must ensure that Molina has up-to-date practice and business information to effectively support and serve both our Members and Provider Network. Keeping the Provider Directory accurate is a regulatory requirement at both the State and Federal levels, as well as an NCQA standard. Incorrect information can hinder Member access to care, affect Member/PCP assignments and referrals, and impact timely and accurate claims processing.

Providers are required to verify their information with Molina for accuracy and completeness at least every 90 days. Additionally, as per the terms of your Provider Agreement, you must inform Molina of any updates to your information as soon as possible, but at least 30 calendar days before the change occurs. This includes, but is not limited to:

- ✓ Change in office location(s), office hours, phone, fax, or email
- ✓ Addition or closure of office location(s)
- ✓ Addition or termination of a Provider (within an existing clinic/practice)
- ✓ Change in Tax ID and/or National Provider Identifier (NPI)
- ✓ Opening or closing your practice to new patients (PCPs only)
- ✓ 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.

Please visit our Provider Online Directory at MolinaHealthcare.com 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.

Provider Directory - Continued

Molina Healthcare providers may request a copy of our Provider Directory from their Provider Services Representative or may use the Online Directory on our website.

To find a provider, you can also visit our website at MolinaHealthcare.com and click “Find a Doctor or Pharmacy.”

Subcontractors Quick Reference Guide

Vision

Marketplace
Vision Service Plan (VSP)
(800) 615-1883
www.vsp.com

MMA/Specialty/LTC
iCare Solutions
(855) 373-7627

Laboratory Services

Quest Diagnostics
866-MYQUEST (866) 697-8378
www.questdiagnostics.com

LabCorp
(800) 845-6167
www.labcorp.com

Pharmacy Benefits

CVS Caremark
(800) 237-2767
www.caremark.com/wps/portal

Subcontractors Quick Reference Guide

Physical, Speech, and Occupational Therapy	**American Therapy Administrators/Heath Network One (MMA, Specialty, Comprehensive)** (888) 550-8800 Note: PT/OT/ST services for LTC members are managed directly through Molina
Non-emergency Transportation Services	**Access2Care** (888) 298-4781
Durable Medical Equipment, Home Health, and Home Infusion	**Coastal Care Services** **MMA and Specialty Plan** (855) 481-0505 Note: Durable Medical Equipment, Home Health, and Home Infusion services for LTC and Comprehensive members is managed directly through Molina

Subcontractors Quick Reference Guide

NICU Services	**PROGENY** Utilization Management: Call 888-832-2006 and select option 3 Utilization Management Secure Fax Number: 866-879-0331. This dedicated fax number will be provided by Progeny Health

2

Cardiology, Oncology, Radiology Oncology	**EVOLENT** Prior Authorization request directly to New Century Health via their provider portal at https://my.newcenturyhealth.com/ or you may call New Century Health at 1-888-999-7713.

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.

More information about Molina's Credentialing program, including Policies and Procedures, is available in the Credentialing and Recredentialing section of this Provider Handbook.

Credentialing Checklist (Continued)

The Credentialing Department will verify provider information that includes, but is not limited to:

- Fully completed CAQH Credentialing application (the cred app must mirror the details in the attested CAQH Data system)
- **Fully completed HDO Credentialing application**
- **Fully Enrolled Medicaid ID (needed to bill Medicaid directly & Molina Healthcare)**
- Limited Enrolled Medicaid ID (Required to bill Molina Healthcare)
- Taxonomy must be valid for provider's specialty that is affiliated to the appropriate Medicaid ID & NPI
- Current, unrestricted license to practice
- Current, valid Drug Enforcement Agency (DEA) certificate
- Education and training
- Work history from the time of medical school graduation
- Board Certification
- Clinical admitting hospital privileges in good standing
- Current, adequate malpractice liability coverage
- All professional liability claims history
- References (if applicable)
- Appropriate (24) hour coverage
- Identify any disciplinary actions and/or sanctions
- Query the National Practitioner Data Bank (NPDB)

Recredentialing

Once a provider or facility is approved for participation in Molina Healthcare's network, re-credentialing is performed every 3 years.

You will receive a re-credentialing application approximately 6 months before your credentialing period is to expire.

The format used is that of a "profile" and only information that may have changed since the last credentialing will be requested.

Information that is reviewed as part of the re-credentialing process includes but is not limited to:

- ✓ Verifying that our providers continue to meet the basic qualifications
- ✓ Information from reported quality performance issues, such as utilization data, member satisfaction surveys and customer service reports
- ✓ A Site Audit is required every 3 years for all rendering Primary Care & Obstetrics, Gynecology Providers Service Locations

Benefits of EMR Access

- Molina will have the ability to download what is needed per measure
- Eliminate the burden from the office staff to Molina
- Transparency with Provider office and Molina
- Limited download of member chart
- Improve compliance & Increase HEDIS Scores
- Limit outreach to the office for additional records
- Extract Supplement Data year around
- COVID-Virus Safety

EMR Access

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 Essentials portal.

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

In-Network Specialist Referrals

A referral becomes necessary when a Provider determines that medically required services exceed the scope of the PCP's practice or require consultation with in-network specialty health professionals, unless it involves Emergency Services. To ensure continuity of care, the PCP and specialist should exchange information, and referrals must be documented in the patient's medical record, including details about the specialty, requested services, and the diagnosis.

Providers should direct Members to Molina-contracted and credentialed health professionals, hospitals, laboratories, and other facilities. For urgent and emergency situations, Providers may direct Members to suitable services such as primary care, urgent care, or hospital emergency rooms.

- 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 can refer a Member to an in-network specialist for consultation and treatment without a referral request to Molina.
- Providers can request a referral from Availity Essentials Portal: Provider.MolinaHealthcare.com

Please Note: The referral requirement does not affect Molina's Prior Authorization guidelines. Therefore, services that require prior authorization will continue to require clinical review and prior approval by Molina and will not be reimbursed without a referral.

Specialists should continue to submit requests directly to Molina for services that require prior authorization, and not direct members back to their PCPs to submit the authorization requests on behalf of the specialists.

Ex.: Non-Par Specialist referrals will still require Prior Authorization.

Coordination of Care

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.

Timely Access Standards

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.

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.

Provider Notifications

Providers must immediately notify Molina, if any of the following events occur:

- Provider's business license to practice in any state is suspended, surrendered, revoked, terminated, or subject to terms of probation or other restrictions.
- Provider has any malpractice claim asserted against it by a Molina member, or any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of provider pursuant to a judgment rendered upon such a claim.
- Provider is the subject of any criminal investigation or proceeding.
- Provider is convicted for crimes involving moral turpitude or felonies.
- Provider is named in any civil claim that may jeopardize financial soundness.
- There is a change in business address, telephone number, ownership, or Tax ID Number.
- Provider's professional or general liability insurance is reduced or canceled.
- Provider becomes incapacitated such that the incapacity may interfere with member care for 24 hours.
- Any material change or addition to the information submitted as part of provider's application for participation with Molina.
- Any other act, event or occurrence which materially affects ability to carry out duties under the Provider Services Agreement.

Duty to Report

Abuse, Neglect and Exploitation

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.

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

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

"**Abuse**" means any willful act or threatened act by a caregiver that causes or is likely to cause significant impairment to an enrollee's physical, mental, or emotional health. Abuse includes acts and omissions.

The Critical Incident Form is located on Molina Healthcare's website at:
http://www.molinahealthcare.com/providers/fl/PDF/Medicaid/forms_FL_CriticalIncidentReportingForm.pdf

To report a critical incident, provider should email the Critical Incident Form to:
MFLQIAlerts@MolinaHealthCare.com

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

Duty to Report (Continued)

Abuse, Neglect and Exploitation

"**Exploitation**" of a vulnerable adult means a person who:

1. Stands in a position of trust and confidence with a vulnerable adult and knowingly, by deception or intimidation, obtains or uses, or endeavors to obtain or use, a vulnerable adult's funds, assets, or property for the benefit of someone other than the vulnerable adult.
2. Knows or should know that the vulnerable adult lacks the capacity to consent, and obtains or uses, or endeavors to obtain or use, the vulnerable adult's funds, assets, or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the vulnerable adult.

"Neglect" of an adult means the failure or omission on the part of the caregiver to provide the care, supervision, and services necessary to maintain the physical and behavioral health of the vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, that a prudent person would consider essential for the well-being of the vulnerable adult. The term "neglect" also means the failure of a caregiver to make a reasonable effort to protect a vulnerable adult from abuse, neglect, or exploitation by others. "Neglect" is repeated conduct or a single incident of carelessness that produces, or could reasonably be expected to result in, serious physical or psychological injury or a substantial risk of death.

"Neglect" of a child occurs when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment, or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, behavioral, or emotional health to be significantly impaired or to be in danger of being significantly impaired.

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.

Duty to Report (Continued)

Abuse, Neglect and Exploitation

Reporting of Abuse, Neglect or Exploitation Including Critical and Adverse Incidents

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.

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 childcare givers.
- Psychologists, social workers, family protection workers, or family protection specialists.
- Attorneys, ministers, or law enforcement officers.

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.

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.

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.

Duty to Report (Continued)

Human Trafficking

Sex Trafficking: The recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age.

Labor Trafficking: The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services using force, fraud, or coercion, for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

Human trafficking may occur in:

- Prostitution and escort services
- Pornography, stripping, or exotic dancing
- Massage parlors
- Agricultural work
- Factory work or sweat shops
- Businesses like hotels, nail salons, or home cleaning services
- Begging, street peddling or door-to-door-sales
- Domestic labor (cleaning, childcare, etc.)

Victims of human trafficking may exhibit:

- Evidence of being controlled either physically or psychologically
- Inability to leave home or work
- Inability to speak for oneself or share one's own information
- Loss of control of one's own identification documents
- Having few or no personal possessions
- Loss of sense of time or space, not knowing where they are or what city or state they are in

Duty to Report (Continued)

Important Contacts

Abuse can be reported by calling the Florida Abuse Hotline, a statewide toll-free number:
1-800-96ABUSE (1-800-962-2873)

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

For more information on human trafficking, visit:

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

Critical/Adverse Incident Reporting Exceptions

MMA

Molina Healthcare 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.

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.

Critical/Adverse Incident Reporting Exceptions - Continuation

Serious Adverse Event (SAEs) Reporting:

SAEs are reportable for members with Behavioral Health conditions, who are designated as in the Child Welfare program, and for those who have HIV/AIDs.

Reportable SAEs include:

- Suicide
- Victim of Homicide
- Baker Act of an enrollee aged 21 years or younger
- Death of enrollee within one year of delivery or pregnancy termination
- Death of enrollee within one year of life
- Victim of abuse, neglect, or exploitation defined by Section 415.102, F.S.
- Sexual battery or altercation requiring medical intervention
- Resident elopement for enrollees in assisted care communities as defined by Section 429.41, F.S.

Providers should report these events as soon as possible to Molina's contact center or care management.

Fraud, Waste and Abuse

Federal and state resources dedicated to the prevention and detection of health care fraud have increased substantially in the past few years as part of the effort to control federal program expenditures. Molina is committed to working with federal and state regulatory and law enforcement agencies to help prevent and detect fraud, and to recover funds paid for fraudulent claims.

	State	Federal
Abuse	Means provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care. (409.913 F.S.)	Means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. (42 CFR 455.2)
Fraud	Means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law. (409.913 F.S.)	Means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR 455.2).
Overpayment	Includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake. (409.913 F.S.)	N/A
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. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs to the Medicaid program.	N/A

Examples of Fraud, Waste, and Abuse

- Paying or receiving kickbacks for member enrollment or service referrals
- Submitting claims for services not rendered and/or falsifying medical records to increase payment
- Double billing services
- Balance billing members
- Billing services separately that should be billed using a single code (unbundling) or adding modifiers when not appropriate to increase payment
- Use of a medical identification card by someone other than the person identified on the card
- Forgery or alteration of a prescription
- Participating in schemes that involve collusion between a provider and a member, such as diverting controlled substance medications for street sales

If you suspect fraud, waste, or abuse, please report it by contacting the Molina AlertLine, an external reporting system managed by NAVEX Global, available 24/7 throughout the year. You can choose to remain confidential or anonymous; if you call, a trained NAVEX Global professional will document your concerns for the Molina Compliance Department, while the web-based process involves answering questions and submitting your report.

Reporting Fraud, Waste and Abuse

You may report suspected cases of fraud and abuse to **Molina's AlertLine** at: 866-606-3889.
https://molinahealthcare.AlertLine.com

To submit written report to Molina Healthcare of Florida via mail or fax:

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

You may also report directly to the **Florida Medicaid Consumer Complaint Hotline** at: 888-419-3456.
https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx

Remember to include the following information when reporting:

- Nature of complaint.
- The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, Medicaid ID number and any other identifying information.

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/.

Reporting Fraud, Waste and Abuse (Continued)

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.

Cultural Competency & Linguistic Services

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.

You Matter to Molina Program

Molina Healthcare of Florida's "You matter to Molina" program prioritizes connecting directly with our network and supporting their efforts to deliver high-quality and efficient health care for Molina members.

Through the "You Matter to Molina" program, we have a dedicated Provider Service Team to intake and resolve your questions or issues and solicit input and feedback from you, our network providers and administrative staff, about ways Molina can improve our technology, tools and process to minimize administrative hurdles and better support you.

Molina is committed to partnering with our network providers to work together to solve problems quickly and efficiently as to why we have taken the initiative to specifically design new solutions to simplify ways for providers to engage with the health plan.

What do we do with all that feedback, you ask?
We determine whether or not action can be taken—if we can take action, we will—and then we'll tell you about it in the success stories section of the You Matter to Molina Corner of the Provider Bulletin.

Surveys

It Matters to Molina Suggestion Box
Provider Experience Survey
Hospital Experience Survey
Provider Training Survey
Provider Bulletin Survey
Molina Provider Data Validation Survey

[You Matter to Molina (molinahealthcare.com)]

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

Community Engagement (Continued)

Coordination with Outside Organizations

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.

Questions

For a copy of this presentation please email:
MFLProviderNetworkManagement@MolinaHealthcare.com