Provider Orientation

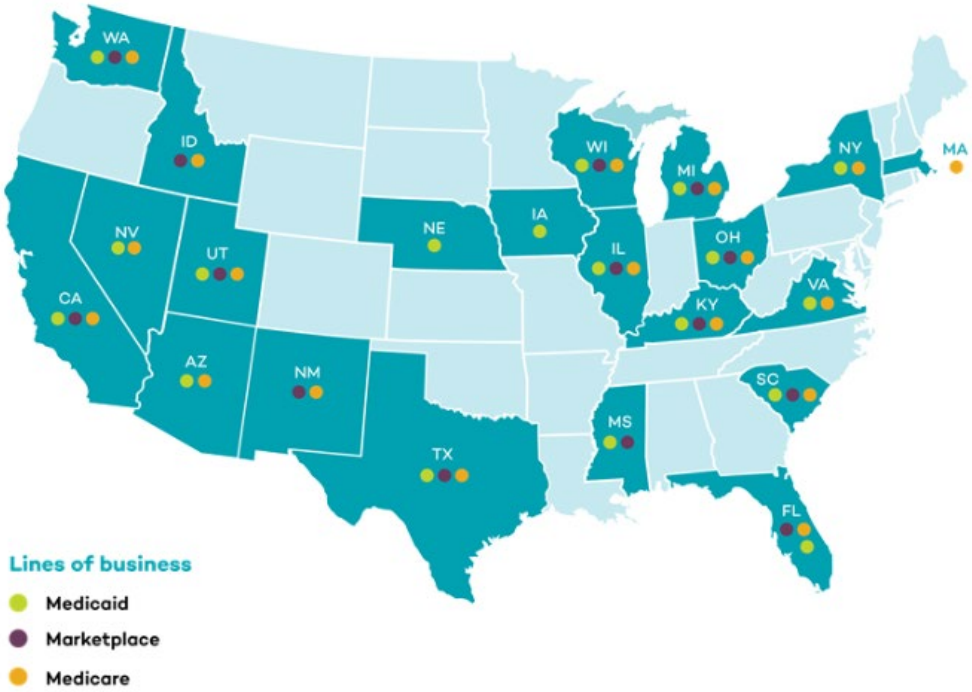
2024 | Molina Healthcare

MOLINA HEALTHCARE

MHO-PROV-0119
0124

Agenda

- Provider Resources
- Availity Essentials Portal
- Quality
- Pharmacy
- Health Care Services (Utilization Management/Care Management)
- Billing and Claims
- Appeals and Grievances
- Compliance
- Provider Training
- Contact Molina



Molina Healthcare

Molina Healthcare, Inc., a FORTUNE 500 company, provides managed health care services under the Medicaid and Medicare programs, and through the state insurance marketplaces.

Through its locally operated health plans, Molina served approximately 5.1 million members nationwide.

Medicaid: Provides a member-centered approach with a wide range of quality health care services to families and individuals who qualify for government-sponsored programs

Medicare: Medicare Advantage plans designed to meet the needs of individuals with Medicare

MyCare Ohio: A member-centered health care approach for people who are eligible for both Medicare and Medicaid

Marketplace: Offers plans that remove financial barriers to quality care and keep members' out-of-pocket expenses to a minimum

Provider Resources

MOLINA HEALTHCARE

Provider Relations

Satisfaction

- Provider Relations Representatives and Engagement Teams
- Annual Assessment of Provider Satisfaction
- The You Matter to Molina Program that Includes Monthly Forums, surveys, and an Information Page on the Provider Website

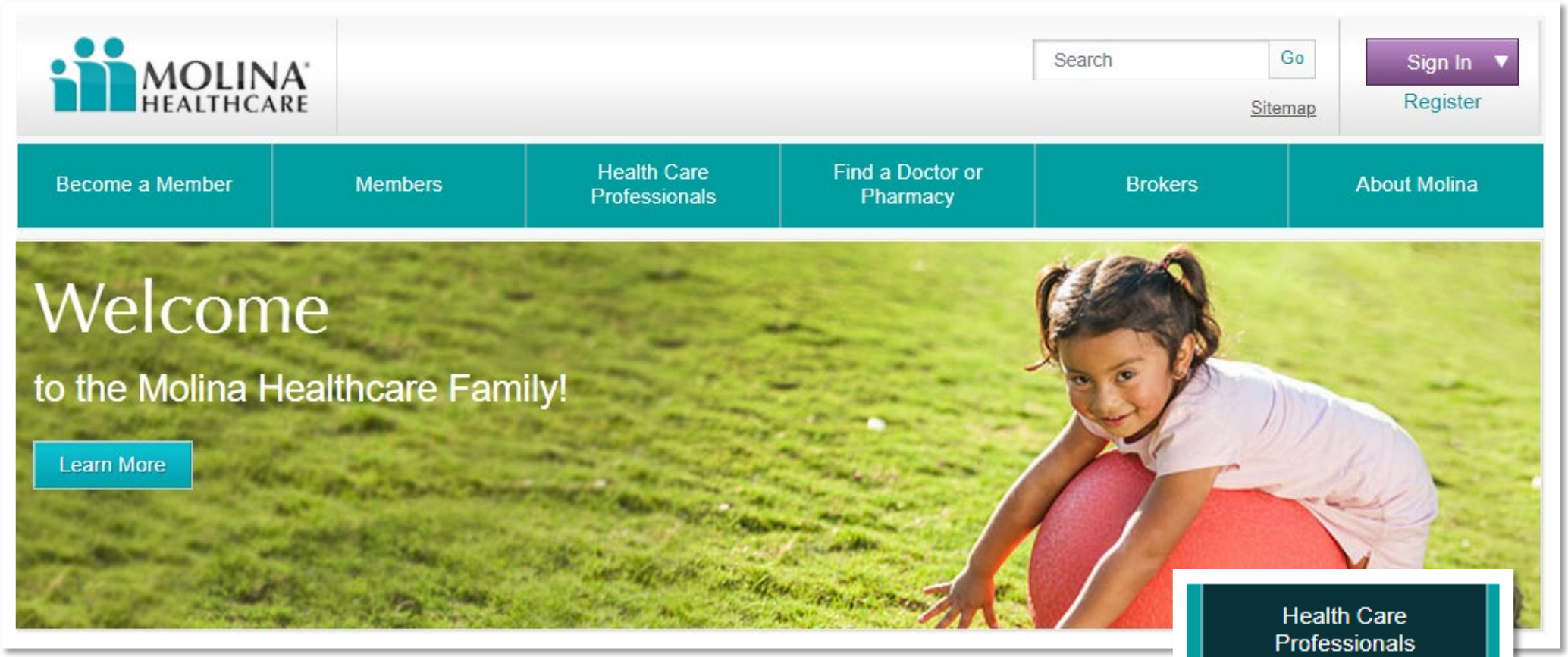
Communication

- Provider Bulletin and Provider Newsletters
- Online Provider Manuals
- Online Trainings, Health Resources, and Provider Resource Guides
- Secure Messaging on the Availity Essentials Portal (Availity)

Technology

- 24-hour Provider Portal
- Online Prior Authorization and Claim Dispute Submission
- Supplemental Prior Authorization (PA) Lookup Tool on Provider Portal and Provider Website
- MCG Auto-Authorization for Advanced Imaging PA Submission
- Availity Overpayments

Provider Website



Molina has a Provider Website for each line of business, available under the Health Care Professionals drop-down menu.

Find the Provider Website at MolinaHealthcare.com.

Provider Online Resources

Molina's Provider Website has a variety of online resources:

- Provider Manual
- Dental Manual
- Claims Information
- You Matter to Molina Page and a Claims Payment Systemic Errors (CPSE) Page
- Contact Information
- Provider Online Directory

- Availity Essentials Portal
- Member Rights and Responsibilities
- Preventive and Clinical Care Guidelines
- Prior Authorization Information
- Claim Dispute
- Provider Communications: Provider Bulletins and Provider Newsletters
- Fraud, Waste, and Abuse Information
- Advanced Directives
- Molina Payment Policies
  Molina Clinical Policies
- Pharmacy Information
- Health Insurance Portability and Accountability Act (HIPAA)
- Frequently Used Forms

Provider Manual Highlights

Provider Manuals are specific to each line of business. Each Provider Manual is customarily updated annually but may be updated more frequently. Information in the Provider Manual includes:

- Benefits and Covered Services
- Claims and Compensation
- Member Appeals and Grievances
- Credentialing and Recredentialing
- Delegation Oversight
- Enrollment and Disenrollment
- Eligibility
- Health Care Services
- Interpreter Services
- HIPAA
- Member Rights and Responsibilities
- Preventive Health Guidelines
- Quality Improvement
- Transportation Services
- Referral and Authorizations
- Provider Responsibilities
- Pharmacy
- Address and Phone Numbers
- Provider Data Accuracy
- Long-Term Services and Supports

Provider Bulletin

A monthly Provider Bulletin is sent to Molina's provider network to report updates.

The Provider Bulletin includes:

- Prior authorization changes
- Training opportunities
- Updates to the Availity Essentials Portal
- You Matter to Molina Corner
- Changes in policies that could affect:
  - Claim submissions
  - Billing procedures
  - Payment
  - Disputes & Appeals (Reconsiderations)

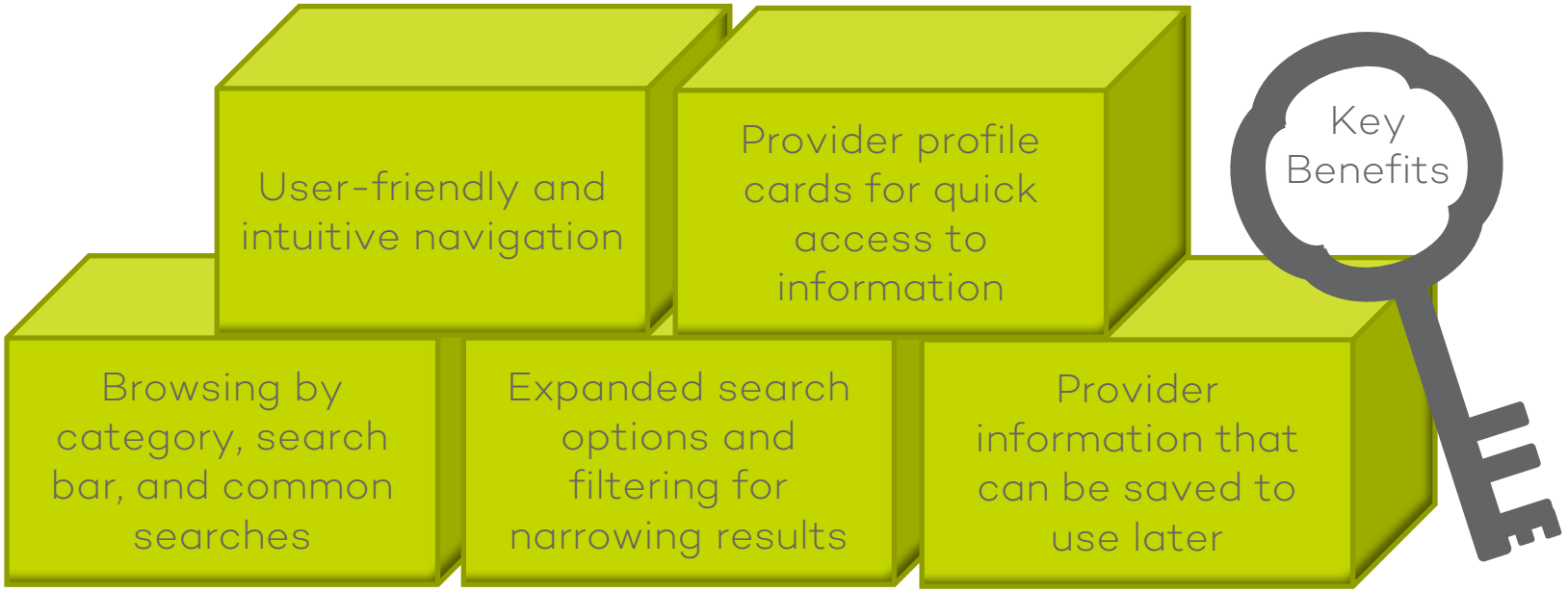
To join our distribution list, visit our Provider Website at MolinaHealthcare.com and under the "Communications" tab, on the "Provider Bulletin" page select "click here."

Molina Provider Online Directory

To find a Molina provider, click "Find a Doctor or Pharmacy"

The Molina Provider Online Directory offers enhanced search functionality so information is available quickly and easily.

Providers are encouraged to use the Provider Online Directory linked on our Provider Website to find a network provider or specialist.

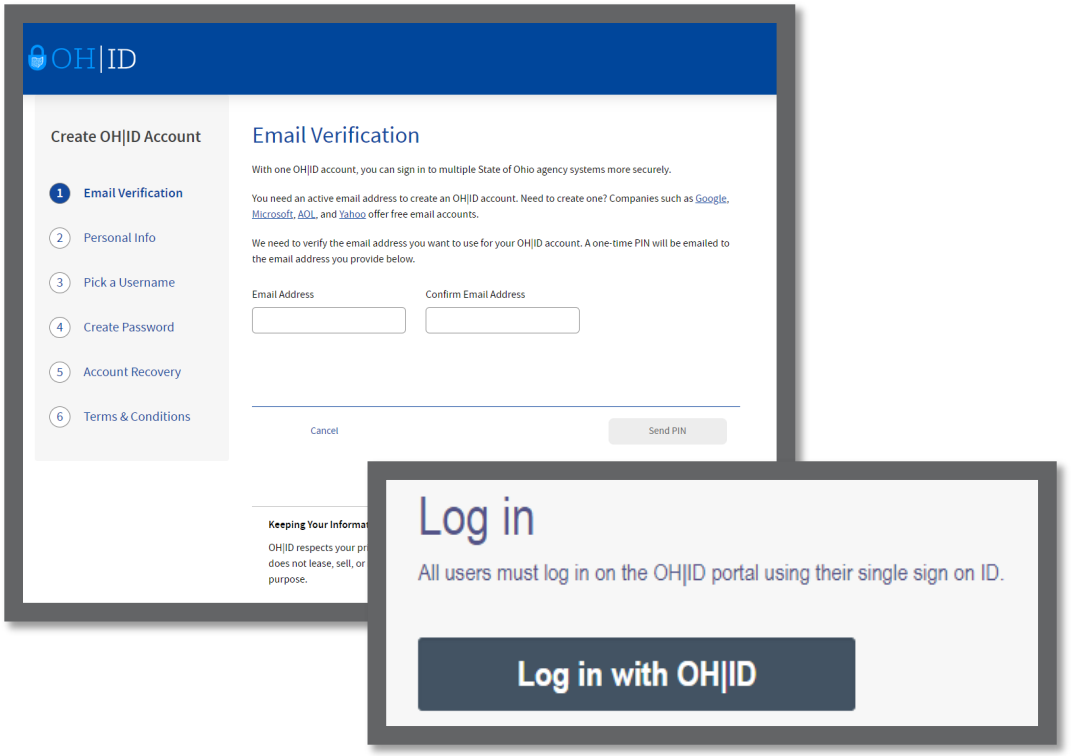


Reminder: Members should be referred to participating providers.

ODM Provider Online Directory and OH|ID

As of Oct. 1, 2022, the Ohio Department of Medicaid (ODM) launched the Provider Network Management (PNM) module to develop a comprehensive provider directory at the state level. View the ODM Quick Reference Guides to learn more.

Important! Medicaid providers are required to obtain a State of Ohio ID (OH|ID) to do business with Ohio Medicaid. Register at Create Account | OH|ID | Ohio's State Digital Identity Standard.



An OH|ID is a personal online user account that provides a secure, personalized experience for providers to interact with multiple state agencies, programs, and services—all with a single username and password.

Find out more in the ODM Provider Network Management Frequently Asked Questions.

Provider Data Accuracy

Maintaining an accurate and current Provider Directory is a state and federal regulatory requirement, as well as a National Committee for Quality Assurance (NCQA)-required element.

Medicaid and MyCare Ohio: On Oct. 1, 2022, ODM migrated to the new PNM system for provider information and updates. View the ODM Quick Reference Guides for more information. Note: The Provider Information Update Form may still be required for some Medicaid and MyCare Ohio updates.

Medicare and Marketplace: Providers can update their information via the Council for Affordable Quality Healthcare (CAQH) DirectAssure application or by submitting a Provider Information Update Form to Molina.

Important Reminders:

- Providers must validate their information at least quarterly for correctness and completeness.
- Notice of changes must be made at least 30 days in advance of any of the following:
  - Change in office location, office hours, phone, fax, or email
  - Addition or closure of an office location
  - Addition or termination of a provider
  - Change in Practice Name, Tax ID and/or National Provider Identifier (NPI)
  - Open or close your practice to new patients (PCP only)

Molina ID Cards

Providers are encouraged to review the most up-to-date version of the Molina Member ID Cards available in our Provider Manuals at MolinaHealthcare.com on the "Manual" page.

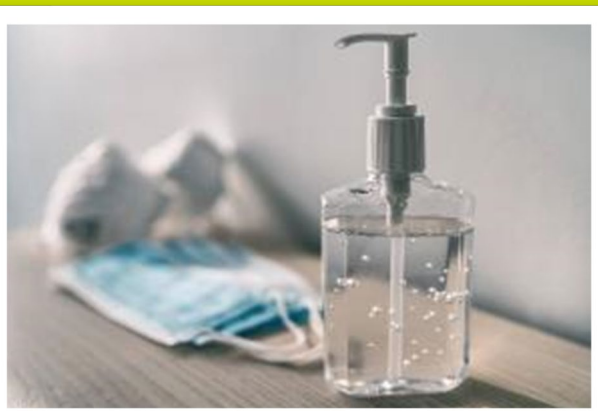
- Medicaid Member Cards
- MyCare Ohio Member Cards
- Medicare Member Card
- Marketplace Member Card

Resuming Medicaid Renewals (Redeterminations)

During the COVID-19 public health emergency (PHE), Medicaid enrollees received uninterrupted health care coverage without annual proof of eligibility. Some state Medicaid agencies continued their eligibility review process, but enrollees were not terminated due to ineligibility.

On December 29, 2022, President Joe Biden signed the Consolidated Appropriations Act of 2023 (also known as the omnibus spending bill) into law, which included the resumption of Medicaid renewals.

Previously, the resumption of Medicaid renewals was tied to the termination of the PHE. With the passage of this bill, the continuous coverage requirements that paused all Medicaid renewals at the start of the PHE are decoupled from the PHE unwinding and termination date of April 1, 2023.



Reference:
appropriations.senate.gov/imo/media/doc/JRQ121922.PDF

Find additional information on the ODM Website at Resuming Routine Medicaid Eligibility Operations | Medicaid (ohio.gov)

Partnering with Us on Medicaid Renewals

We're asking for your support and partnership. Together, we can provide the education and resources to retain our Medicaid members and offer solutions to those in our communities who have lost their coverage during the recertification process.

How Can You Help?

We need your help reminding your Medicaid patients to update their contact information and renew their benefits, so they don't lose their coverage. You can help us by:

- Looking for their Medicaid renewal date in your Availity provider portal's eligibility & benefits and member roster sections (see specific steps on the Provider Website Renewals FAQ page).
- Liking and sharing our Facebook page and posts or by posting your own social media posts and tagging us in the posts.

Find additional information about Medicaid Renewals at Molina Healthcare Medicaid Renewals.

How Can Members Renew?

Online: Log in to benefits.ohio.gov and click the "Renew my Benefits" tab.

By Phone: Call the Ohio Medicaid Consumer Hotline at (800) 324-8680, option 8 (TTY: (800) 292-3572). Call Monday through Friday, 7 a.m. to 8 p.m.

By Mail: Complete the Medicaid Renewal Form received in the mail. Send it to their local County Department of Job and Family Services (CDJFS). They can find the address on the front page of the letter or on the County Agency Directory.

In Person: Visit their local CDJFS office. Bring the documents needed to report income and fill out a form in person. Find the address at County Directory (ohio.gov).








MOLINA HEALTHCARE

Prior Authorization (PA)

Prior Authorization (PA) is a request for prospective review. Requests for services on the Molina PA Code List are evaluated by licensed nurses and trained staff.

Health Care Professionals

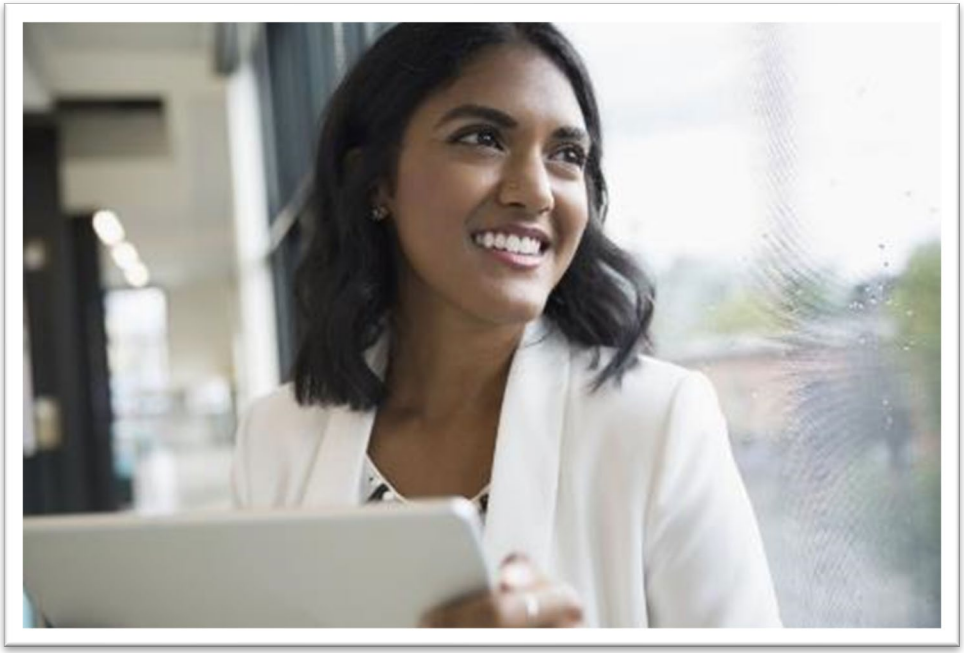
- Medicaid
- Medicare
- MyCare Ohio
- Marketplace
- Provider Portal
- Prior Auth LookUp Tool

Utilize the PA Lookup Tool on our Provider Website and Provider Portal to determine if a PA is required

Provider Responsibilities

Molina expects our contracted providers will respect the privacy of Molina members (including Molina members who are not patients of the provider) and comply with all applicable laws and regulations regarding the privacy of patient and member Protected Health Information (PHI).

For additional information view the "Provider Responsibilities" section of the Provider Manual, located at MolinaHealthcare.com under the "Manual" tab. Topics include:



- Non-Discrimination of Health Care Service Delivery
- Provider Data Accuracy and Validation
- National Plan and Provider Enumeration System (NPPES) Data Verification
- Electronic Solutions/Tools Available to Providers
- Primary Care Provider (PCP) Responsibilities

You Matter to Molina

At Molina of Ohio, our providers matter! Our "You Matter to Molina" program connects us directly to our entire network of providers as we support their efforts to delivery high-quality and efficient health care for Molina members.

- The program gives providers access to monthly Provider Bulletins, newsletters, trainings, surveys, presentations, videos, resource documents, reference guides and more.
- Free access to the PsychHub platform offering free mental health educational courses and CEU opportunities for providers, as well as patient-facing resources.
- Availity Essentials Portal access and training resources.
- Learn more now at MolinaHealthcare.com/OH/YouMatterToMolina.

Thank you for being part of the Molina family.

Medicaid Definitions of Terms: Authorization Appeal and Claim Disputes

Authorization Appeal

Formerly known as an "authorization reconsideration." A provider dispute for the denial of a PA. Should be submitted on the Authorization Reconsideration Form (Authorization Appeal and Clinical Claim Dispute Request Form) and submitted via fax.

Clinical Claim Dispute

Formerly known as an "authorization reconsideration." A post-claim provider dispute for the denial of a PA or a retro-authorization request for Extenuating Circumstances. Must be submitted on the Authorization Reconsideration Form (Authorization Appeal and Clinical Claim Dispute Request Form). May be submitted via Availity, fax, or verbally.

Non-Clinical Claim Dispute

Formerly known as a "claim reconsideration." This process is used only for disputing a payment denial, payment amount, or a code edit. The Non-Clinical Claim Dispute must be submitted on the Claim Reconsideration Form (Non-Clinical Claim Dispute Form). May be submitted via Availity, fax, or verbally.

MyCare Ohio, Medicare and Marketplace Definitions of Terms: Authorization Reconsideration and Claim Reconsideration

Authorization Reconsideration is either:

- A provider dispute for the denial of a PA. Should be submitted on the Authorization Reconsideration Form and submitted via fax.
- A post-claim provider dispute for the denial of a PA or a retro-authorization request for Extenuating Circumstances. Must be submitted on the Authorization Reconsideration Form. May be submitted via Availity or via fax.

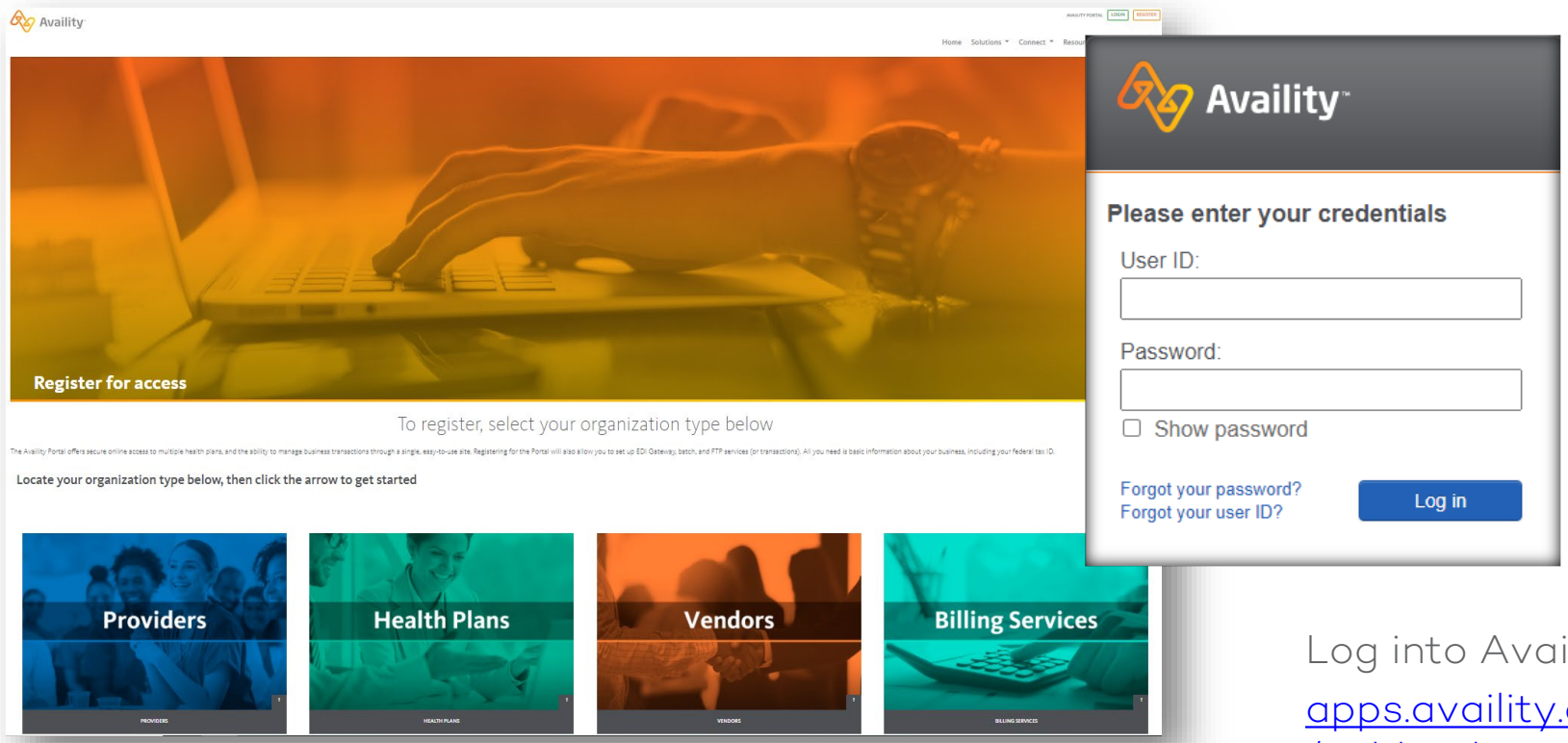
Claim Reconsideration is used only for disputing a payment denial, payment amount, or a code edit. The Claim Reconsideration must be submitted on the Claim Reconsideration Form. May be submitted via Availity or via fax.

Availity Essentials Portal

MOLINA HEALTHCARE

Availity Essentials (Availity) Provider Portal

Register for Availity at availity.com/provider-portal-registration and select your organization type.



Log into Availity at: apps.availity.com/availity/web/public.elegant.login.

Note: After May 23, 2023, providers no longer have direct access to the Molina Provider Portal and its functions.

Availity Provider Portal

Once registered providers will have access to the Availity Portal training by following these steps:

Atypical Providers:
Under "News and Announcements" select "Atypical Providers: Here's your Ticket to Working with the Availity Portal" to view training sessions.

Availity Provider Portal

The Availity Provider Portal is secure and available 24 hours a day, seven days a week. Self-service Provider Portal options include:

- Online Claim Submission
- Claims Status Inquiry
- Corrected Claims
- Member Eligibility Verification and Benefits
- Secure Messaging
- Check Status of Claim Dispute

- Manage Overpayment Request
- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Online Non-Clinical Claim Dispute (Claim Reconsideration) Requests
- Care Coordination Portal
- Remittance Viewer
- View PCP Member Roster
- Submit and Check Status of PA Requests

Quality

MOLINA HEALTHCARE

Quality Improvement

Molina's Quality Improvement Department leverages quality improvement science and best practices to ensure measurable improvements in the care and service provided to our members.

Molina's Quality Improvement Program complies with regulatory requirements and accreditation standards.

The Quality Improvement Program provides structure and outlines specific activities designed to improve the care, service, and health of our members.

For more information on Molina's Health Management Program, call the Health Education line at (866) 472-9483

For more information about Molina's Quality Improvement initiatives, reach out to Molina at (855) 322-4079

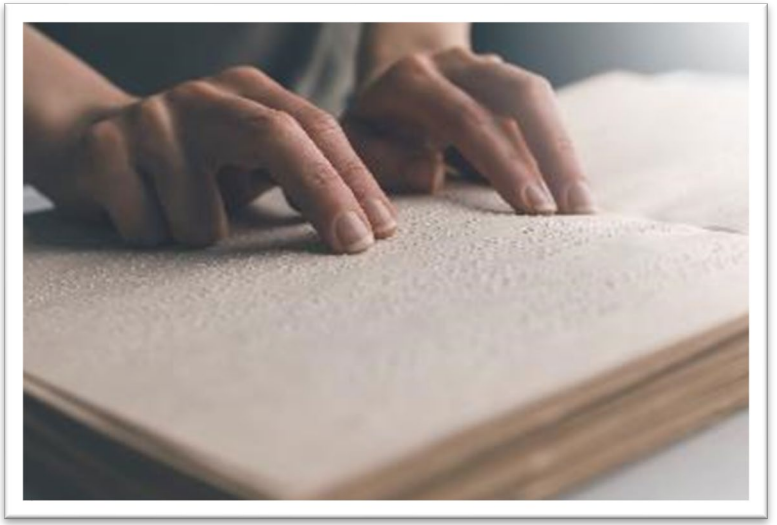
View Molina's Clinical Practice Guidelines and Preventive Health Guidelines on the Provider Website

Access to Care Standards

Molina maintains access to care standards and processes for ongoing monitoring of access to health care provided by contracted PCPs and Specialists.

Providers may not discriminate against any member on the basis of any of the following:

- Gender Identity or Sex Stereotyping
- Socioeconomic Status
- Pregnancy
- Religion
- Health Status, Status as Recipient of Medicaid Benefits, or Need for Health Services
- Physical, Mental, or Sensory Disability
- National Origin or Ancestry
- Marital Status
- Military Status
- Sex or Sexual Orientation
- Place of Residence
- Age, Race, Creed, Color, or Genetic Information
- Medical (physical or mental) condition, or the expectation of frequent or high-cost care



If you choose to close your panel to new members, you must give Molina 30 days' advance written notice.

Access to Care Standards

Molina maintains access to care standards and processes for ongoing monitoring of access to health care (including behavioral health) provided by contracted PCP (adult and pediatric) and participating specialists (including OB/GYN, behavioral health providers, and high volume and high impact specialists).

Molina provides appointment access standard timeframes in the Quality chapter of our Provider Manuals.

- Medicaid Provider Manual
- Medicare Provider Manual
- MyCare Ohio Provider Manual
- Marketplace Provider Manual

Additional information on appointment access standards is available from the Molina Quality Department at (855) 322-4079.

Access to Care Standards, Continued

For scheduled appointments, the wait time in offices should not exceed 30 minutes.

All PCPs are required to monitor waiting times and adhere to this standard.

All providers must have back-up (on call) coverage after hours or during the provider's absence or unavailability.

Providers must maintain a 24-hour telephone service, 7 days a week. Access may be through an answering service or a recorded message after office hours.

The service or recorded message should instruct members with an emergency to hang up and call 911 or go immediately to the nearest emergency room.

Voicemail alone after-hours is not acceptable.

Note: Medicaid providers must offer hours to Molina members that are comparable to commercial plans or Medicaid Fee-for-Service

Measurement of Clinical and Service Quality

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

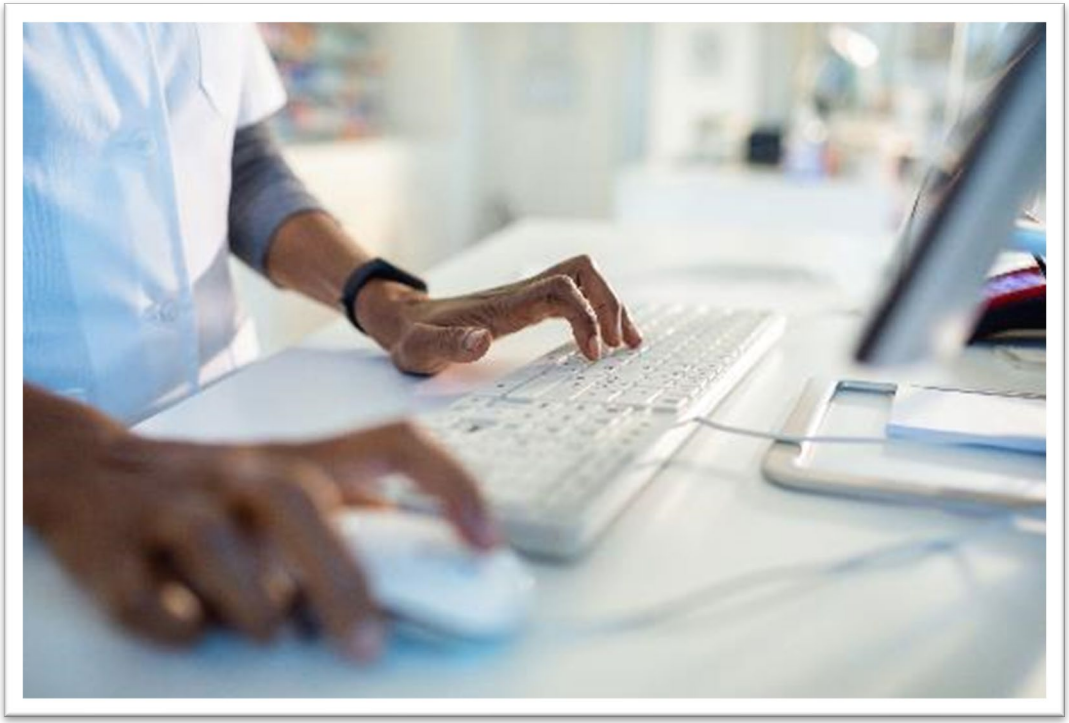
Find out more in the Quality chapter of each Provider Manual.

Pharmacy

MOLINA HEALTHCARE

Pharmacy: Medicaid Single Pharmacy Benefit Manager

In accordance with Ohio Revised Code (ORC) section 5167.24, ODM selected Gainwell Technologies, a third-party administrator, to serve as a statewide Single Pharmacy Benefit Manager (SPBM) to be responsible for providing and managing pharmacy benefits for Molina and other Managed Care Organizations' (MCO) members.



The SPBM is a specialized managed care program that will provide pharmacy benefits for the entire Medicaid managed care population (excluding MyCare Ohio members).

All Medicaid managed care members will be automatically enrolled with the SPBM.

The SPBM will provide coverage for medications dispensed from contracted pharmacy providers.

Note: Provider-administered medications supplied by non-pharmacy Providers (such as hospitals, clinics, and physician practices) will continue to be covered by Molina or the OhioRISE plan, as applicable.

Drug Formulary: Medicaid Single Pharmacy Benefit Manager

Gainwell uses the ODM Unified Preferred Drug List (UPDL). The UPDL is a list of prescription drugs that are recommended for doctors to use. The UPDL is also called a Formulary.

- All Medicaid managed care organizations and Fee-for-Service (FFS) use the same ODM Unified Preferred Drug List.
- Some drugs require PA. Providers must submit a PA request to Gainwell and explain why a specific medication and/or a certain amount of a medication is needed.
- Gainwell is responsible for prescription drug prior authorizations, claims, and processing.
- View the current Unified Preferred Drug List on ODM's Website.
- View the Unified Preferred Drug List updates for the current quarter (30-Day Change Notice) on ODM's Website.

Find additional information on the SPBM and Pharmacy Pricing and Audit Consultant (PPAC) page of the ODM Website.

Pharmacy: MyCare Ohio, Medicare, and Marketplace

Prescriptions for medications requiring prior authorization or for medications not included on the Drug Formulary may be approved when medically necessary and when Drug Formulary alternatives have demonstrated ineffectiveness.

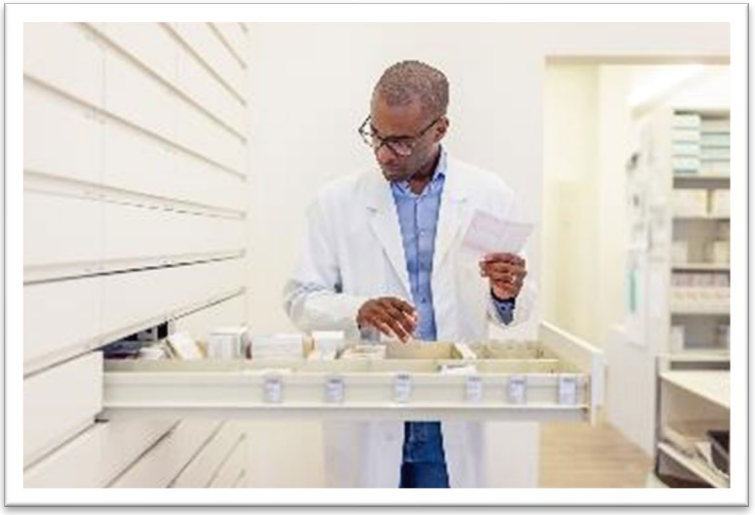
When these exceptional needs arise, providers may fax a completed Prior Authorization/Medication Exception Request to Molina. These forms are available on the Molina Provider Website, under the “Forms” tab.

PA Pharmacy Fax:
Marketplace: (800) 961-5160

PA Pharmacy Fax:
MyCare Ohio and Medicare: (866) 290-1309

Drug Formulary: MyCare Ohio, Medicare, and Marketplace

The Molina of Ohio Drug Formularies for MyCare Ohio, Medicare, and Marketplace are available on the Provider Website.



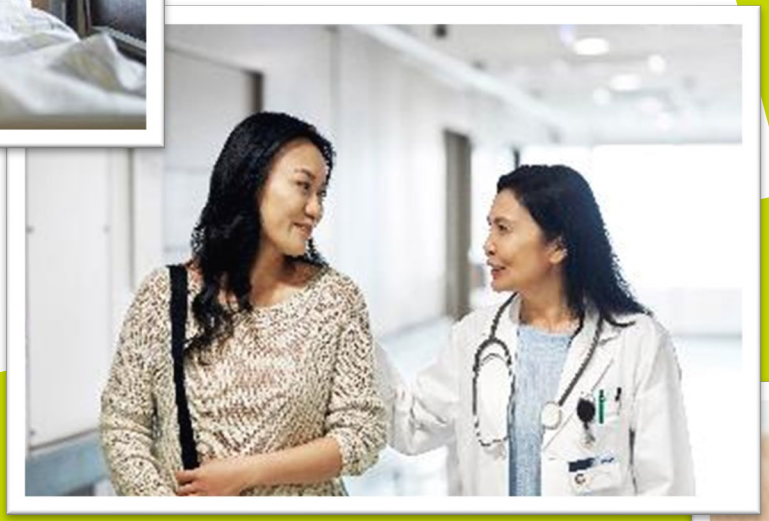
Health Care Services (Utilization Management/ Care Management)

MOLINA HEALTHCARE

Health Care Services

Health Care Services is comprised of:

- Utilization Management (UM)
- Care Management (CM)



The Health Care Services Department:

- Conducts concurrent review on inpatient cases
- Processes prior authorizations and service requests
- Performs care management for members who will benefit from care management services

Key Functions

Resource Management

- PA and referral management
- Pre-admission, Admission and Inpatient Review
- Referrals for Discharge Planning and Care Transitions
- Staff education on consistent application of UM functions

Eligibility and Oversight

- Eligibility verification
- Benefit administration and interpretation
- Verifying current Physician/hospital contract status
- Oversight of UM Delegates
- Ensure authorized care correlates to member's medical necessity need(s) and benefit plan

Quality Management

- Satisfaction evaluation of the UM program using member and provider input
- Utilization data analysis
- Quality oversight
- Monitor for possible over or under-utilization of clinical resources
- Monitor for adherence to Centers for Medicare and Medicaid Services (CMS), NCQA, state and health plan UM standards

Note: "Medical Necessity" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient.

Initial Organization Determination/Pre-Service Authorization Request

A request for expedited determinations may be made. A request is expedited if applying the standard determination timeframes could seriously jeopardize the life or health of the member, or the member's ability to re-gain maximum function.

Standard/Elective: Must be made as soon as medically necessary

- Medicaid, MyCare Ohio, and Marketplace: Within a maximum of 10 calendar days after receipt of the request
- Medicare:
  - Non-Part B or D: Within a maximum of 14 calendar days after receipt of request
  - Part B and D: Within a maximum of 72 hours after receipt of request

Standard Request vs. Expedited Initial Request

A list of PA fax numbers is available on the Molina Prior Authorization Request Form and Instructions for each line of business.

Expedited/Urgent: Must be made as soon as medically necessary

- Medicaid, MyCare Ohio, and Marketplace: Within 48 hours (including weekends and holidays) following receipt of the validated request
- Medicare:
  - Non-Part B or D: No later than 72 hours after receipt of initial request for services
  - Part B and D: No later than 48 hours after receipt of initial request for services

Clinical Information

Molina requires copies of relevant clinical information be submitted for documentation to ensure accurate and timely clinical decision-making.

Clinical information includes but is not limited to:

- Pertinent Physician Emergency Department Notes
- Inpatient History/Physical Exams
- Discharge Summaries
- Physician Progress Notes
- Physician Office Notes
- Physician Orders
- Regulatory Required Forms
- Nursing Notes
- Results of Laboratory or Imaging Studies
- Therapy Evaluations
- Therapist Notes

Note: As of May 1, 2023, the maximum clinical information fax size threshold Molina can accept is no more than 100 pages (10 MB) for the total size of the fax transmission.

Care Management

Molina provides care management services to members to address a broad spectrum of needs, including chronic conditions that require the coordination and provisions of health care services.

Care Management focuses on members who have been identified for Molina's Integrated Care Management (ICM) Program.

	The ICM Program:	
Provides care coordination and health education for disease management		Identifies and addresses psychosocial barriers to accessing care
Maintains the goal of promoting high quality care that aligns with a member's individual health care goal		To initiate, the member is screened for appropriateness for ICM Program enrollment using specified criteria

Referral to care management may be made by any of the following:

- Member/ Representative
- PCP/Specialist
- Hospital Staff
- Molina Staff
- Home Health Staff

Care Manager

The Role of a Care Manager Includes:		
Coordination of quality and cost-effective services	Appropriate application of benefits for the member	
Assistance with transitions between care settings and/or providers	Attention to member preference and satisfaction	
Referral to, and coordination of, appropriate resources and support services	Promotion of interventions in the least restrictive setting of the member's choice	
Promote utilization of multidisciplinary clinical, behavioral and rehabilitative services	Creation of Individualized Care Plan (ICP), updated as the member's conditions, needs and/or health status change	Provision of ongoing analysis and evaluation of the member's progress towards ICP adherence

Members may receive health risk assessments that help identify physical health, behavioral health, medication management problems, and social determinants of health to target high-needs members who would benefit from assistance and education from a Care Manager.

Health Care Services Online Resources

Molina has a variety of online Health Resources that are available to providers, including:

Medicaid External Medical Review

An External Medical Review can be requested by a provider as result of:

- Molina's service authorization denial, limitation, reduction, suspension, or termination (includes pre-service, concurrent, or retrospective authorization requests) based on medical necessity; or
- Molina's claim payment denial, limitation, reduction, suspension, or termination based on medical necessity.

Denials, limitations, reductions, suspensions, or terminations based on lack of medical necessity include, but are not limited to decisions made by the plan where:

- Clinical documentation or medical record review is required in making the decision to deny (includes preservice, concurrent, and retrospective reviews).
- Clinical judgement or medical decision making (i.e., referred to a licensed practitioner for review) is involved.
- A clinical standard or medical necessity requirement (e.g., MCG®, ASAM, or Ohio Administrative Code (OAC) 5160-1- 01, including EPSDT criteria, and/or the MCO's clinical coverage or utilization management policy or policies) is not met.

View the External Medical Review section of the Provider Manual for how to request an external medical review.

Billing and Claims

MOLINA HEALTHCARE

Payer IDs

Medicaid providers utilizing Electronic Data Interchange (EDI) transactions on and after Feb. 1, 2023, must use the ODM Ohio Medicaid Enterprise System (OMES) Fiscal Intermediary for the transaction types noted in the Payer ID grid.

Medical Claims	
Line of Business	**Payer ID**
Ohio Aged, Blind, or Disabled (ABD) (Medicaid)	0007316
Ohio Adult Extension (Medicaid)	0007316
Ohio Healthy Families (Medicaid)	0007316
Molina SKYGEN Dental	D007316
Molina March Vision	V007316
Ohio Marketplace Program	20149
Ohio Marketplace Program Primary with Ohio Medicaid Secondary (ABD, Adult Extension, Healthy Families)	20149
Medicare-Medicaid Plan (MMP) Medicare (MyCare Ohio)	20149
MMP Medicaid (MyCare Ohio)	20149
MMP Opt-Out/MMP Medicaid Secondary (MyCare Ohio)	20149
Medicare Advantage Prescription Drug (MAPD)	20149

Claims Submission Options

Providers must utilize electronic billing through a Clearinghouse, the Availity Provider Portal, or the ODM OMES EDI process as the One Front Door*:

Option #1 Clearinghouse

- Change Healthcare is the outside vendor used by Molina MyCare Ohio, Medicare and Marketplace
  - Providers may use any clearinghouse
- Trading Partners must connect to OMES as the ODM EDI system for Medicaid claims submission

Option #2 Provider Portal

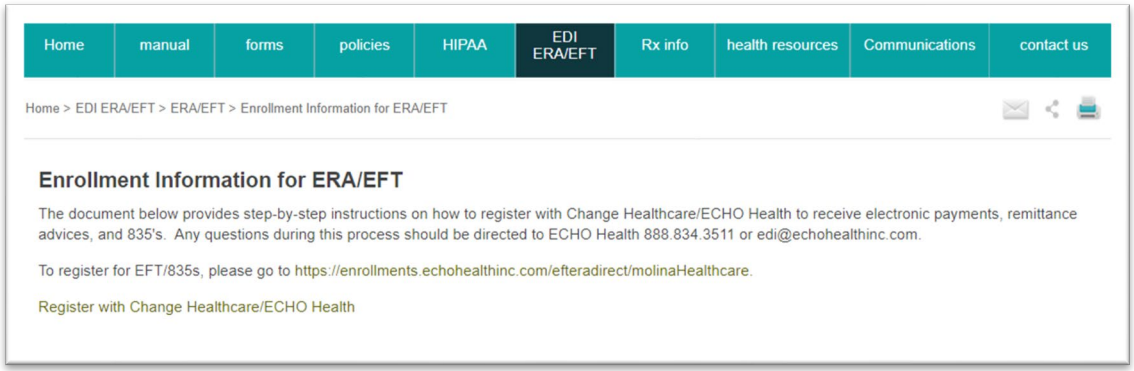
- Availity Essentials Portal: Online submission is available for Medicaid, MyCare Ohio, Medicare and Marketplace
- PNM System for Medicaid: Once launched by ODM, direct data entry claims must be submitted via the PNM Portal

*Applies only to Medicaid line of business.

Change Healthcare ERA/EFT

Molina contracts with our payment vendor, **Change Healthcare**, who has partnered with ECHO Health, Inc., for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA).

Access to Change Healthcare is **FREE** to our providers. We encourage you to register for ECHO at ECHO Health after receiving your first check from Molina.



If you have any questions about the registration process, contact Change Healthcare at (888) 834-3511 or via email at edi@echohealthinc.com.

Visit the EDI ERA/EFT pages at MolinaHealthcare.com for additional information.

If there is no payment preference specified on the ECHO platform, the payment will be issued via a Virtual Card. Find out more about the Virtual Card in the Molina Provider Manual.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Medicaid-eligible children are entitled to receive a comprehensive package of preventive health care.

This includes all well-child care recommended by the American Academy of Pediatrics (AAP) and the EPSDT child health requirements, known as Healthchek in Ohio.

Molina requires the EPSDT data reported in block 24H be submitted on all EPSDT claims. If this field is left blank, the claim will be denied.

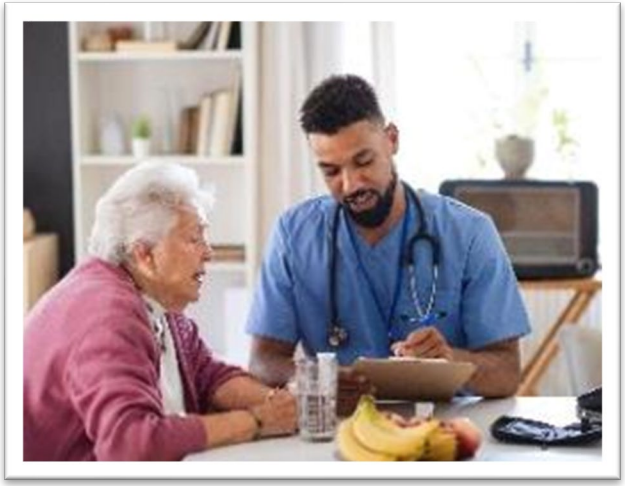
ODM is federally required to annually report the number of EPSDT visits and referrals for follow-up or corrective treatment for Medicaid-eligible recipients 0 to 21 years of age.

Find more details on how to bill EPSDT claims in the ODM Billing Guides.

For more billing information, visit the Healthchek-EPSDT page on the Molina Provider Website.

Electronic Visit Verification

ODM implemented Electronic Visit Verification (EVV) for some Home and Community-Based Service (HCBS) providers in response to federal requirements set forth in section 12006 of the H.R. 34 (114th Congress) (2015-2016) of the 21st Century Cures Act.



EVV applies to HCBS providers who will bill the following codes: G0151, G0152, G0153, G0156, G0299, G0300, S5125, T1000, T1001, T1002, T1003, T1019, and T2025.

EVV is an electronic system that verifies key information about the services rendered by the provider including date of service, service start and end time, individual receiving the service, person providing the service, and the location of the service.

EVV applies to state plan home health aide, state plan home health nursing, private duty nursing, state plan registered nurse assessment, HCBS 1915c waiver nursing, HCBS 1915c waiver personal care aide, and HCBS 1915c waiver home care attendant.

ODM has contracted with Sandata Technologies LLC to provide the EVV system at no cost to providers or individuals receiving services. For additional details visit the EVV page on the ODM website.

Note: Upon future notice by ODM, Molina will begin denying claims for providers who do not utilize the EVV system.

Appeals and Grievances

MOLINA HEALTHCARE

Member Appeals, Grievances, and Complaints

Appeal	An appeal is the request for a review of an adverse benefit determination.
Grievance	The Ohio Administrative Code defines a grievance as an expression of dissatisfaction with any aspect of Molina or participating providers' operations, provision of health care services, activities, or behaviors.
Complaint	A complaint is any dissatisfaction that a member has with Molina or any participating provider that is not related to the denial of health care services.

Molina members or their authorized representatives have the right to voice a grievance or submit an appeal through a formal process.

Members may authorize a designated representative to act on their behalf with written consent. The representative can be a friend, a family member, health care provider, or an attorney.

Molina ensures that members have access to the appeals process by providing assistance in a culturally and linguistically appropriate manner; including oral, written, and language assistance. Information is also included in the Member Handbook.

Member Appeals, Grievances, and Complaints, Continued

Members may file an appeal, grievance, or complaint by calling Molina's Member Services Department:

Medicaid:
(800) 642-4168 (TTY/Ohio Relay (800) 750-0750 or 711), Monday - Friday from 7 a.m. to 8 p.m.

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

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

Medicare:
(866) 472-4584 (TTY 711), Monday – Sunday from 8 a.m. to 8 p.m.

Marketplace:
(888) 296-7677 (TTY 711), Monday – Friday from 8 a.m. to 7 p.m.

Submit a grievance or complaint in writing to:

Medicaid, Marketplace, and MyCare Ohio Opt-Out:

Molina Healthcare of Ohio, Inc.
Attn: Appeals and Grievances Unit
PO Box 182273
Chattanooga, TN 37422

Medicare and MyCare Ohio Opt-In:

Molina Healthcare Medicare
Attn: Grievances and Appeals
PO Box 22816
Long Beach, CA 90801-9977

Timeframes to Submit an Appeal

- Medicaid: An appeal can be filed verbally or in writing within 60 days from the date of the Notice of Action.
- MyCare Ohio: An appeal can be filed verbally or in writing within 60 days from the date of the denial notice.
- Medicare: Members have 60 days from the date of the denial to file an appeal.
- Marketplace: Members must appeal an adverse benefit determination within 180 days after receiving written notice of the denial.

MOLINA HEALTHCARE

Member Appeals Represented by the Provider

Molina will investigate, resolve, and notify the member/representative of the findings no later than the following time frames:

Receipt of Standard Appeal Requests

- 7 calendar days of receipt for Medicare Part B Drug Appeals
- 15 calendar days of receipt for Medicaid and Molina Dual Options MyCare Ohio Appeals
- 30 calendar days of receipt for Marketplace and Pre-Service Medicare
- 60 calendar days of receipt for Post-Service Medicare Appeals

Receipt of Expedited Appeal Requests

- Determine within one business day if the appeal request meets expedited criteria
- If the appeal request meets expedited criteria, resolve within 72 hours of receipt for Medicaid, Medicare and Molina Dual Options MyCare Ohio Appeals
- If the appeal request meets expedited criteria, resolve within 48 hours of receipt for Marketplace

Members must exhaust the internal appeals process prior to filing an external appeal (e.g., State Fair Hearing or Independent External Review).

If the appeal resolution isn't fully in the member's favor, Molina will notify the member of their external appeal rights.

Member Appeal Represented by the Provider

For member appeals represented by the provider, Molina must have written consent from the member authorizing someone else to represent them.

- Note: Member consent is not required for Medicare and Molina Dual Options MyCare Ohio Plan (MMP) pre-service appeals. For post-service appeals, non-contracted providers must sign a Waiver of Liability statement for the appeal to be valid.

An appeal can be filed verbally or in writing within 60 days from the date of the Notice of Action.

The grid below summarizes your options by type of authorization and line of business:

	Outpatient			Inpatient		
	P2P	Authorization Reconsideration (Appeal or Clinical Claim Dispute)	Provider Represented Member Appeal	P2P	Authorization Reconsideration (Appeal or Clinical Claim Dispute)	Provider Represented Member Appeal
Medicaid/ Marketplace	Yes	Yes	Yes	Yes	Yes	Yes
Medicare/ MyCare Ohio	Yes*	No	Yes	Yes	Yes	Yes

* Due to regulatory requirements, for Medicare/MyCare Ohio outpatient decisions, a Peer-to-Peer (P2P) is a consultation only. A determination cannot be overturned via the P2P process.

If a patient wants the provider to appeal on their behalf, the patient must tell Molina in writing using the Appeal Representative Form.

Member Grievances and Complaints

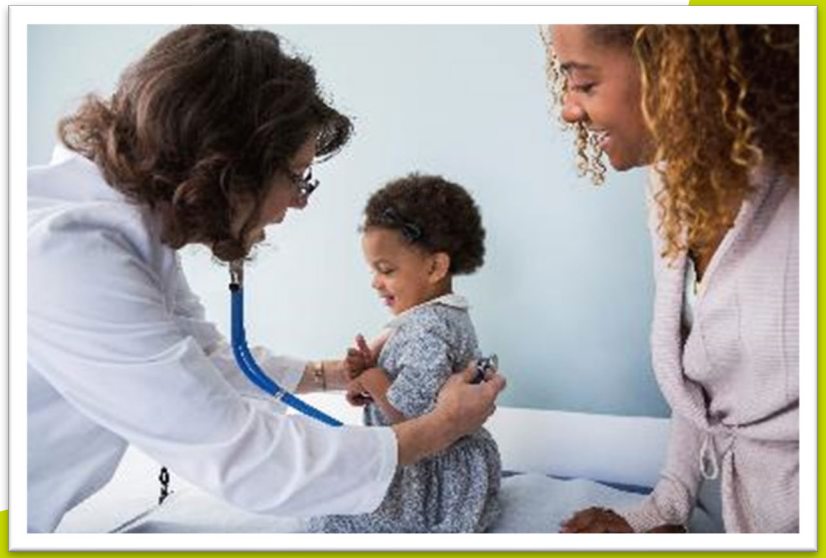
Grievances and Complaints: Molina will investigate, resolve, and notify the member or representative of the findings no later than the following time frames:

Marketplace	Medicaid	Medicare	Molina Dual Options MyCare Ohio Plan
• Access Grievance: 60 Calendar Days • Standard Grievance: 60 Calendar Days • Billing Grievance: 60 Calendar Days	• Access Grievance: 2 Business Days • Standard Grievance: 30 Calendar Days • Billing Grievance: 60 Calendar Days	• Access Grievance: 2 Business Days • Standard Grievance: 30 Calendar Days	• Access Grievance: 2 Business Days • Standard Grievance: 30 Calendar Days

Quality of Care and Potential Quality of Care Grievances

A Quality of Care (QOC) grievance is a type of grievance that is related to whether the quality of covered services provided by a plan or provider meets professionally recognized standards of health care.

- Potential Quality of Care issues (PQOC) can be identified/reported by any employee, member, caregiver, and/or provider.
- PQOCs include Serious Reportable Adverse Events (SRAE)/Hospital Acquired Conditions (HAC) and Never Events.
- The direction a PQOC/QOC investigation takes is dependent on the issue being reviewed.



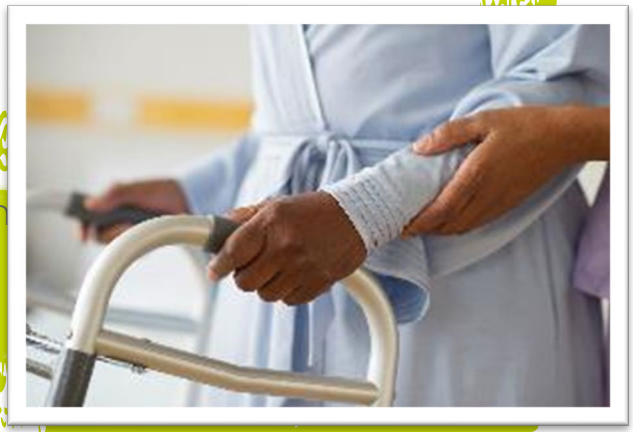
- The PQOC/QOC investigation could involve inappropriateness of care, poor continuity of care, refusal of care, or the provider's plan of treatment which may have a negative impact on the member's health.
- Provider expectations for PQOC/QOC are based on their contractual obligation to participate in the quality process and can include responding to requests for medical records or additional information.

QOC and PQOC Grievances, Continued

Examples of QOC/PQOC grievances include care that adversely impacted or had the potential to adversely impact the member's health, and can include any of the following:

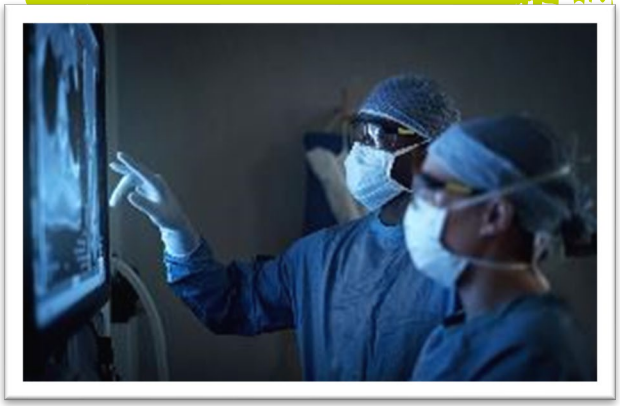
Medication Safety: Any medication error or inadequate medication management.

- Member is prescribed medication to which they are allergic
- Member is prescribed new medication and provider does not monitor the therapeutic effects



Procedure/Surgery: Wrong operation/procedure on a patient or wron patient or unscheduled return to surgery.

- Member readmitted to the hospital with post-surgical complications



Treatment: Delay in diagnosis, treatment, or repetition of procedure, or delay in or failure to refer.

- Abnormal lab results were not communicated to member or there was a failure to refer to an alternative provider for follow up
- Lack of ordering necessary labs

Quality of Service Grievances

Quality of Service (QOS) is defined as any expression of dissatisfaction with the behavior of provider/staff, customer service received, or physical appearance of place of service.

QOS examples include reported rudeness of provider/office staff, long wait time for a scheduled appointment, not enough chairs in reception area to accommodate waiting patients.

Provider Relations Representatives will reach out to the office to get the provider details on the QOS, that will then be shared with ODM.

QOS requests have a due date which will be shared with your office.

Failure to respond or provide information on the QOS will be reported back to ODM as provider non-responsive.

Compliance

MOLINA HEALTHCARE

Medicaid ID Number

In order to comply with federal rule 42 CFR 438.602, providers are required to have enrolled or applied for enrollment with the ODM at both the group practice and individual levels to receive payment for clean claims submitted to Molina for covered services.

Providers without a Medicaid ID number will need to submit an application to ODM. Providers can start the process at medicaid.ohio.gov.

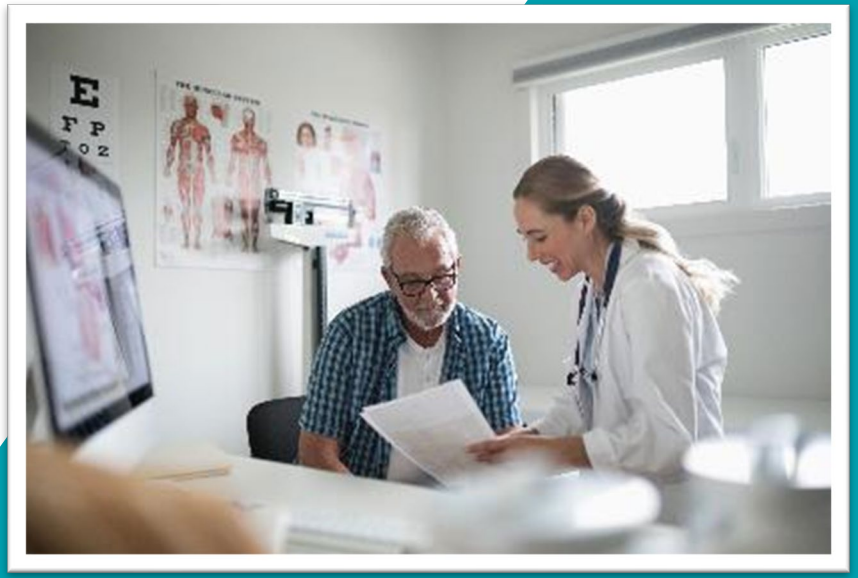
For dates of service on Feb. 1, 2023, and after, Molina denies claims for providers who are not registered and active in the state's system. Providers who update their records after claims begin rejecting will need to submit corrected claims once the records are updated.

Health Insurance Portability and Accountability Act (H

HIPAA requires providers to implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of a member's PHI.

- Providers should recognize that identity theft is a rapidly growing problem and that their patients trust them to keep their most sensitive information private and confidential
- Molina strongly supports the use of electronic transactions to streamline health care administrative activities
- Providers are encouraged to submit claims and other transactions using electronic formats

Molina is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers who wish to conduct HIPAA standard transactions with Molina should refer to the HIPAA Transactions on our Provider Website under the "HIPAA" tab.



Certain electronic transactions are subject to HIPAA Transactions and Code Sets Rule including, but not limited to, the following:

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

MOLINA HEALTHCARE

Cultural & Linguistic Competency





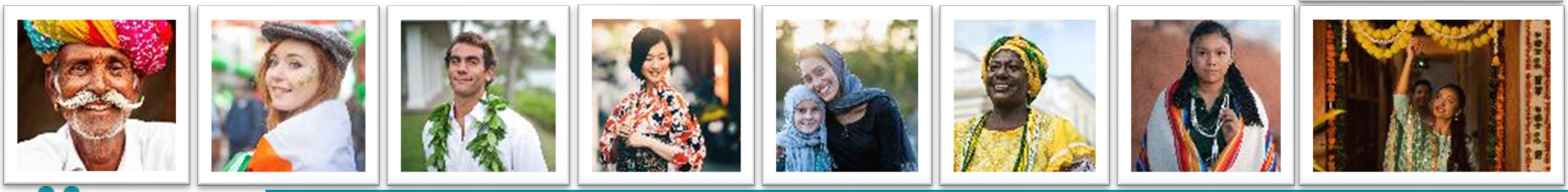
Per CMS rule 42 Code of Federal Regulations (CFR) § 438.10 (h) (1) (vii), Molina is required to validate our network providers' completion of annual Cultural Competency training to ensure providers meet all members' unique and diverse needs.

Molina offers educational opportunities in cultural competency concepts for providers, their staff, and Community-Based Organizations. Providers may:

- Utilize Molina's training, located on the Culturally and Linguistically Appropriate Resources/Disability Resources page and attest to Molina
- Utilize their own Cultural Competency training that meets the federal requirement and attest to Molina

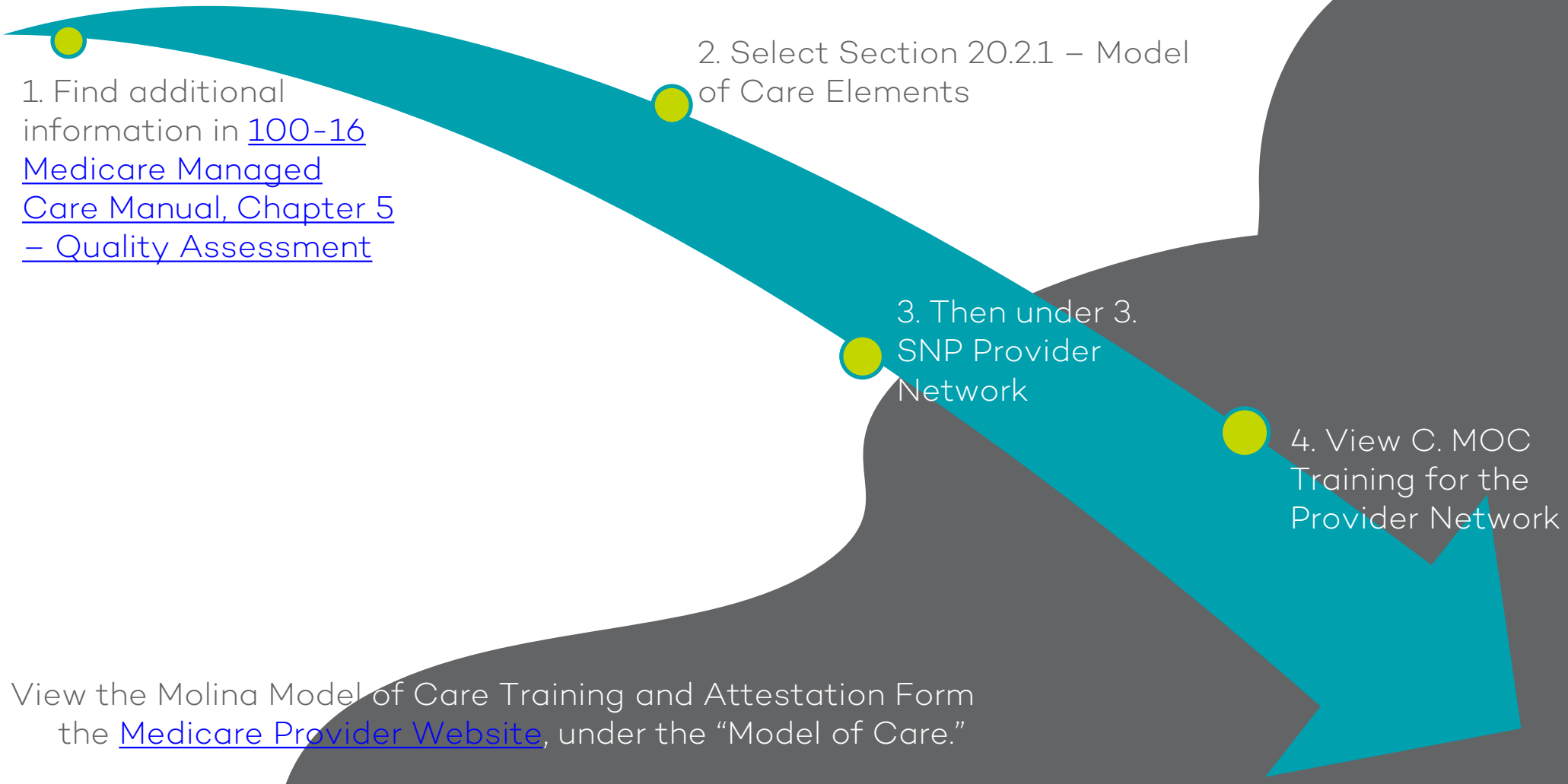
Email the completed Molina Cultural Competency Attestation Form, available on our Provider Website, to OHAttestationForms@MolinaHealthcare.com.

Please note: Molina does not review and assess providers' training programs.



Model of Care

CMS requires certain contracted Medicare medical providers to complete an annual basic training and attest to the Molina specific Dual Eligible Special Needs Plan (D-SNP) Model of Care.



View the Molina Model of Care Training and Attestation Form the Medicare Provider Website, under the "Model of Care."

Americans with Disabilities Act (ADA)

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

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

The ADA is based on three underlying values:

- Equal Opportunity
- Integration
- Full Participation

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

Anti-Discrimination Regulations

Molina complies with Title VI of the Civil Rights Act, the 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 identity, 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

For more information view the "Nondiscrimination of Health Care Services Delivery" section of the Provider Manual at MolinaHealthcare.com.

Ownership and Control Disclosure Form

Providers are required to complete the Ownership and Control Disclosure Form during the contracting process or at any time disclosure needs to be made to the plan.

Providers are required to disclose any changes in Ownership and Control information in accordance with:

- 42 CFR 455.104 Disclosure by Medicaid Providers and Fiscal Agents: Information on Ownership and Control
- 42 CFR 455.105 Disclosure by Providers: Information Related to Business Transactions
- 42 CFR 438.230 Subcontractual Relationships and Delegation
- OAC 5160-1-17.3 Provider Disclosure Requirements

Providers who are contracted through a group affiliation should fill out the form at the group level. If a provider is contracted as an individual or independent provider, the form should be filled out at the provider level.

The Ownership and Control Disclosure Form is available at MolinaHealthcare.com.

Fraud, Waste, and Abuse

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

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

For more information read the "Fraud, Waste, and Abuse" section of our Provider Manual at MolinaHealthcare.com.

Information includes:

- Introduction and Mission Statement
- Definitions
- Regulatory Requirements
- Review of Provider Claims and Claims System
- Examples of Fraud, Waste, and Abuse by Members and Providers
- Prepayment Fraud, Waste, and Abuse Detection Activities
- Post-payment Recovery Activities

Member Advance Health Care Directives (Advance Directives)

Advance Directives are documents that state a member's wishes about receiving medical care and/or end-of-life care choices if the member is no longer able to make medical decisions due to serious illness or injury.

Anyone 18 years old or older who is of sound mind and able to make their own decisions can complete the document(s).

Are written to follow state laws. A lawyer is not needed to complete an Advance Directive.

Members can change an Advance Directive whenever they want. It is a good idea to look over Advance Directives from time to time to make sure they still represent the member's wishes and cover all areas.

Members can visit caringinfo.org/planning/advance-directives/by-state/ohio/ to access forms for download.

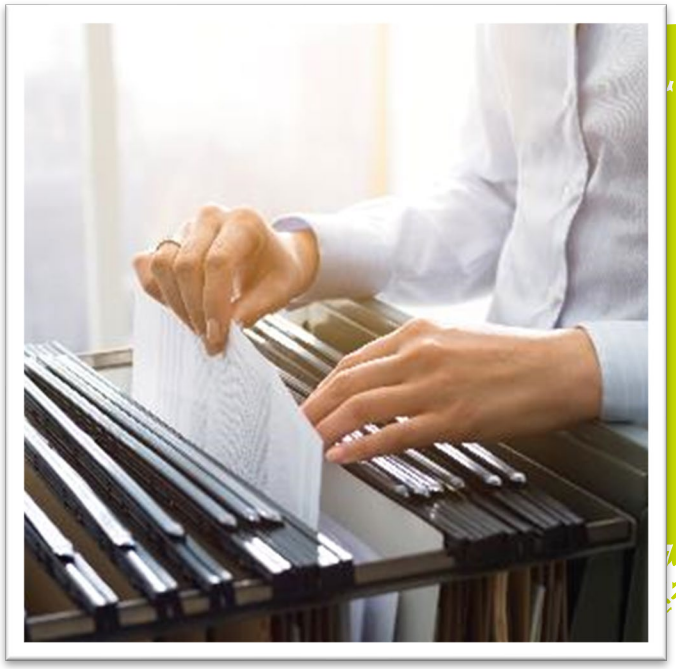
When there are no Advance Directives, the member's family and provider will work together to decide the best care for the member based on the information known about the member's end-of-life plans.

Ohio law includes a conscience clause. If a provider cannot follow an Advance Directive because it goes against their conscience, they must assist in finding another provider to carry out the member's wishes.

Advance Directives, Continued

The four types of Advance Directives include:

- **Durable Power of Attorney for Health Care (Health Care Power of Attorney or Health Care Proxy)** allows an agent to be appointed to carry out health care decisions.
- **A Living Will** allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration.
- **Guardian Appointment** allows one to nominate someone to be appointed as Guardian if a court determines that a guardian is necessary.
- **A Declaration for Mental Health Treatment** allows a member to appoint a representative to make decisions while they lack the capacity to do so.



Find out more about Advance Directives in the Molina Provider Manual Quality chapter.

Note: A DNR is written by a doctor, or in certain circumstances, a certified nurse practitioner or clinical nurse specialist. It instructs providers against performing CPR.

Advance Directives, Continued

Provider Responsibilities for Advance Directives:		
Providers must inform adult Molina members over 18 of their right to make health care decisions and execute Advance Directives	PCPs must discuss Advance Directives with a member and provide appropriate medical advice if the member desires guidance or assistance	In no event may any provider refuse to treat a member or otherwise discriminate against a member because the member has completed Advance Directives
Molina network providers and facilities are expected to communicate any objections they may have to a member directive prior to service when possible: • Members may select a new PCP if the assigned provider has an objection to the member's desired decision • Molina will facilitate finding a new PCP or specialist	Ohio law includes a conscience clause. If a provider cannot follow an Advance Directive because it goes against their conscience, they must assist the patient in finding another provider who will carry out the patient's wishes • Patients have the right to file a complaint related to Advance Directives with the Ohio Department of Health	Providers are instructed to document the presence of Advance Directives in a prominent location of the Medical Record • Auditors will also look for copies of Advance Directives • Molina will look for documented evidence of the discussion between the Provider and the member during routine Medical Record reviews

Medicaid Critical Incident Reporting

It is the responsibility of Molina and Molina's participating providers credentialed through ODM to ensure the health and welfare of Medicaid members.

We can fulfill such responsibility by maintaining an incident management process by which we report to appropriate agencies and ODM in instances where we believe the member's health and/or welfare may be at risk.

Effective July 1, 2022, the OAC rule 5160-44-05 (Section C. [1-5]) sets forth the Medicaid Critical Incident types required to be reported/reviewed by the MCO or its designee.

To help ensure consistency in application of the OAC 5160-44-05 and consistency in entry of information into the Incident Management System (IMS), the IMS will now afford ability to capture Medicaid critical incidents. The IMS is the system established by ODM in which reported incidents are entered/documented.

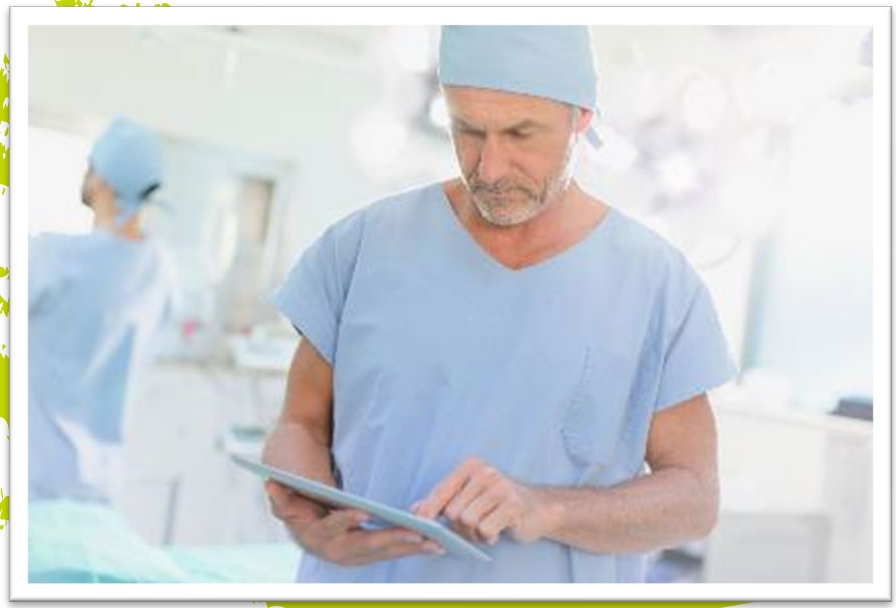
In addition, the IMS facilitates the process of identifying trends and patterns regardless of program or entity/entities serving the member.

Medicaid Implications of Incident Rule 5160-44-05

Upon discovering a Medicaid Critical Incident (CI), the responsible person or entity which discovered it will do all the following:

Ensure immediate action taken to protect the health and welfare of the individual

Notify appropriate entities with investigative or regulatory authority



Communicate to Molina surrounding Medicaid CI by completing Medicaid Critical Incident Referral Template in its entirety and submitting securely to MedicaidCriticalIncident@MolinaHealthcare.com within 24 hours and providing ongoing assistance as warranted

Work collaboratively with Molina as needed to identify potential contributing factors/root causes of the incident, implement remediation/ mitigation strategies, enter review notes and results, and develop a prevention plan if applicable to incident scenario

Medicaid Critical Incident Types, Categories, and Subcategories

Medicaid Critical Incident types are located in OAC 5160-44-05, Section C [1-5] and include abuse, neglect, exploitation, misappropriation greater than $500 and unnatural or accidental death.

Critical Incident Categories	Critical Incident Subcategories
Abuse: the injury, confinement, control, intimidation, or punishment of an individual, that has resulted in physical harm, pain, fear, or mental anguish.	• Physical • Emotional • Verbal • Sexual abuse • Use of restraint, seclusion, or restrictive intervention
Neglect: when there is a duty to do so, failing to provide an individual with any treatment, care, goods, or services necessary to maintain the health or welfare of the individual.	
Exploitation: the unlawful or improper act of using an individual or an individual's resources through the use of manipulation, intimidation, threats, deceptions, or coercion for monetary or personal benefit, profit, or gain.	

Medicaid Critical Incident Types, Categories, and Subcategories, Continued

Critical Incident Categories	Critical Incident Subcategories
Misappropriation: the act of depriving, defrauding, or otherwise obtaining the money, real or personal property (including prescribed medication) of an individual by any means prohibited by law that could potentially impact the health and welfare of the individual.	• Involves theft > $500
Unnatural or accidental death: death that could not have reasonably been expected, or the cause of death is not related to any known medical condition of the individual, including inadequate oversight of prescribed medication or misuse of prescribed medication.	• All deaths of children are required to be reported no matter what the manner or cause of death. In addition, all deaths of individuals enrolled on the OhioRISE program will be reported, regardless of whether or not the incident meets the definition of an unnatural or accidental death.

Medicaid Critical Incident Resources for Providers

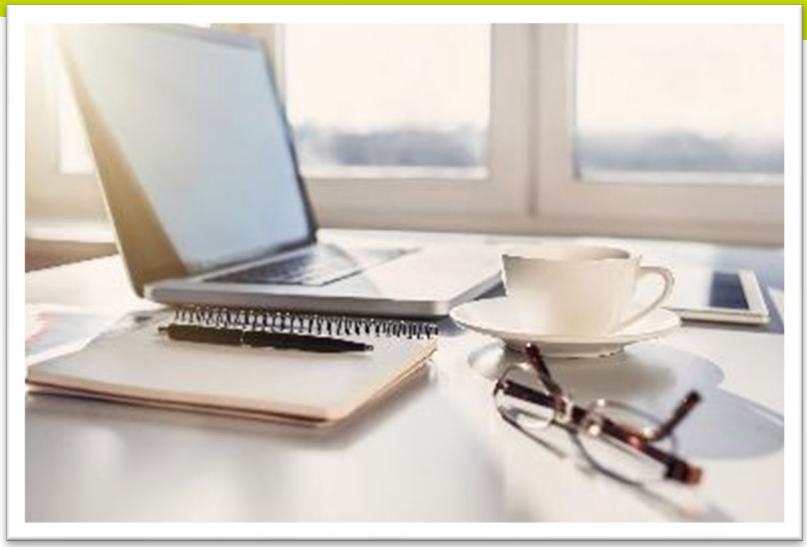
The Medicaid Critical Incident Referral Template is located under the "Other Forms and Resources" heading within Provider Forms section of Molina website Provider Forms (molinahealthcare.com)

A more detailed Provider training PowerPoint presentation is located on Molina website within Communications tab under Molina Presentations heading "You Matter to Molina Forum" section You Matter to Molina (molinahealthcare.com)

MyCare Ohio Incident Reporting

OAC 5160-44-05 sets the standards and procedures for managing incidents that may have a negative impact on individuals. The purpose is to establish the procedures for reporting and addressing Critical Incidents, Reportable Incidents, and Provider Occurrences to implement a continuous quality improvement process to prevent and reduce the risk of harm to Individuals.

OAC 5160-44-05 applies to the Ohio Department of Aging (ODA), ODM, their designees, and the individuals as defined in the OAC. The OAC also applies to providers of waiver services and providers of services under the Specialized Recovery Services (SRS) program. ODA and ODM may designate other entities to perform one or more of the Incident Management functions set forth in the OAC.



SCOPE

- Ohio Home Care Waiver (OHCW)
- MyCare Ohio Waiver
- Specialized Recovery Services Program (SRSP)
- Assisted Living Waiver
- PASSPORT Waiver

MyCare Ohio Waiver Incident Types: 5160-44-05

Critical Incidents

- Neglect
- Exploitation
- Misappropriation
- Unnatural or Accidental Death
- Self-Harm or Suicide Attempt Resulting in ER/Inpatient/Hospitalization
- Individual Lost or Missing
- Prescribed Medication Issues:
    a) Provider error
    b) Prescribed medication issues resulting in emergency medical services, ER visit, or hospitalization

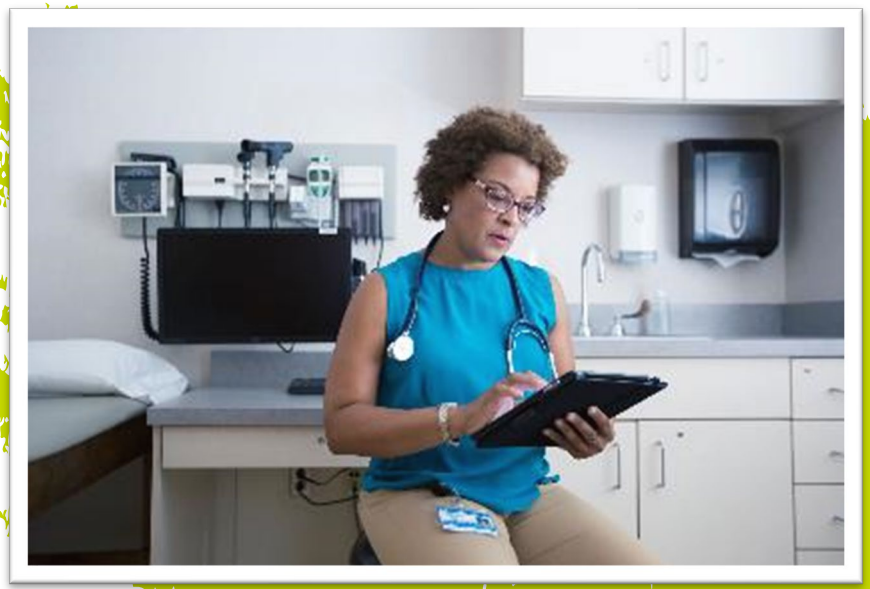
Reportable Incidents

- Natural Deaths
- Health and Safety Action Plan (HSAP)
- Health and Welfare at Risk due to any of the following:
    a) Loss of the individual's paid or unpaid caregiver
    b) Prescribed medication issue not resulting in EMS response, ER visit, or hospitalization
    c) Eviction or housing crisis
- Suicide Attempt – Not resulting in ER/ Inpatient/Hospitalization

MyCare Ohio Implications of Incident Rule 5160-44-05

Upon discovering a MyCare Ohio Critical Incident (CI), the responsible person or entity which discovered it will do all the following:

- Ensure immediate action taken to protect the health and welfare of the individual
- Notify appropriate entities with investigative or regulatory authority
- Communicate any MyCare Ohio CI to Molina by completing Medicaid Critical Incident Referral Template in its entirety and submitting it to the Waiver Care Manager within 24 hours and providing ongoing assistance as warranted



- Work collaboratively with Molina as needed to identify potential contributing factors/root causes of the incident, implement remediation/mitigation strategies, enter review notes and results, and develop a prevention plan if applicable to incident scenario

MyCare Ohio Waiver Provider Occurrences: 5160-44-05

Failure to Coordinate Service Delivery

- Failure to provide services as specified on the person-centered service plan
- Failure to notify when service is not provided

Failure to Report

- Failure to report an incident
- Failure to report a change in the individual or services
- Failure to provide 30-day notice

Prohibited Provider Behavior

Non-Medicaid Fraud Billing Issues

Medicaid Fraud

- Billing for services not rendered
- Falsified documentation/Physician's orders
- Falsified the individual's signature
- Inappropriate billing
- Kickback to/from consumer
- Subcontracting service
- Submitted claim while the individual was institutionalized

Unprofessional Behavior of the Provider

- Failure to provide documentation
- Failure to comply with HIPAA or confidentiality
- Failure to maintain documentation

Provider Training

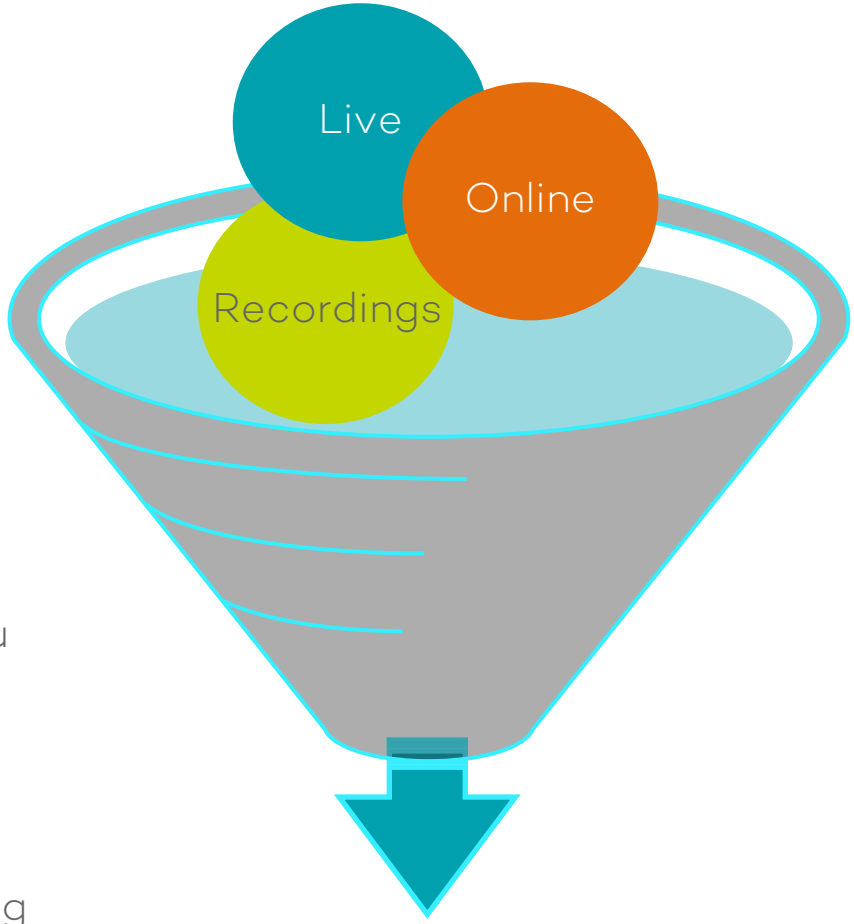
MOLINA HEALTHCARE

Molina Provider Training Opportunities

The Provider Relations Team offers multiple trainings to the provider network throughout the year.

Trainings are available in multiple formats, including:

- **Live**: Molina hosts live trainings each month that includes You Matter to Molina Forums, Provider Orientations, claims and billing information, and more
  - View upcoming trainings dates and times on the You Matter to Molina page
- **Online**: Training presentations are available on the You Matter to Molina page for self-paced learning
  - These provider trainings are available on the Molina Provider Website on the You Matter to Molina page
- **Recordings**: Recordings of some Molina of Ohio training presentations with audio are linked from the You Matter to Molina page. Find additional Molina information on the Molina Healthcare YouTube page



Training Opportunities

These provider trainings are available on the Molina Provider Website on the You Matter to Molina page.

Standard Network Trainings and Specialized Provider Orientations

The Provider Relations Team offers multiple standard trainings to the provider network throughout the year. Any of the standard trainings can be requested by a provider for one-on-one training.

Standard Network Training:

- Monthly General Provider Orientation
- Cultural Competency Videos
- Model of Care Training
- Availity Essentials Portal Training

Specialized Provider Orientation:

- Transportation Services: Covered Services, billing information, and resources
- Nursing Facility and Assisted Living: Covered services, billing information, and resources
- Claims and Billing: Key billing guidelines, modifiers, and general resources
- Health Care Services: Authorization tools, Peer-to-Peers, supporting documentation, Clinical Claim Disputes (Authorization Reconsiderations)

You Matter to Molina Forums

Molina offers You Matter to Molina (IMTM) Forums throughout the year. Topics change from month to month. Previous topics include:

- Pregnancy Related Services Billing
- Home Health Clinical Claim Dispute (Authorization Reconsideration) Process
- Provider Claim and Authorization Reconsideration
- Cost Recovery
- PsychHub
- Notice of Medicare Non-Coverage (NOMNC)

Please share training ideas that would benefit your practice, including references or resources we can develop.

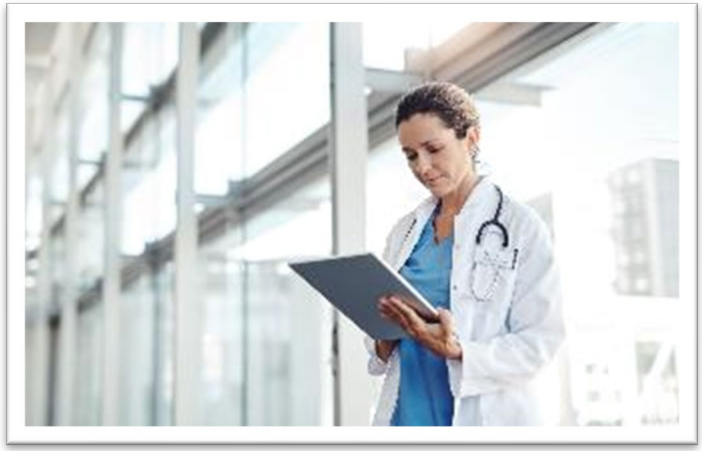
Contact Molina

MOLINA HEALTHCARE

Molina Provider Training Survey

The Molina Provider Relations Team hopes you have found this training session beneficial.

Please share your feedback with us so we can continue to provide you with excellent customer service!



Please take a few minutes to complete the Molina Provider Training survey to provide feedback on this session. The survey is located on the You Matter to Molina Page of our Provider Website, under the "Communications" tab.

Molina wants to hear about what other topics you'd like training on in the future.

Molina of Ohio Provider Relations Contact Information

Molina has designated email addresses based on provider types to help get your questions answered more efficiently or to connect you to training opportunities:

Provider Type	PS Rep.	Email Address
Physician groups, Specialists, FQHC Non-BH Providers, Advanced Imaging/ Radiology, Ambulatory Surgical Centers, Anesthesiologists, and Hospitalists	Jeanneen Williams	OHProviderRelationsPhysician@MolinaHealthcare.com
Skilled Nursing, Long Term Acute Care, Hospice, and Assisted Living Facilities	Yvonne Mitchell	OHProviderRelationsNF@MolinaHealthcare.com
Home Health Agencies, Waiver (LTSS), Laboratories, Ancillary Dialysis Centers, and Durable Medical Equipment	Alexandrea Grier	OHMyCareLTSS@MolinaHealthcare.com
BH Providers (ODMHAS, CMHC, 84/95) and FQHC BH Providers	Mariah Vinson	BHProviderRelations@MolinaHealthcare.com
Multi-Specialty and assists with all provider types	Sarah Stevens	OHProviderRelations@MolinaHealthcare.com

Molina Provider Relations Contact Information, Continued

Contact information for hospital-affiliated providers or groups:

Hospital Region	Representative	Email Address
All State	Jeremy Swingle	OHProvider.RelationsHospital@MolinaHealthcare.com
All State	Christopher Jones	OHProvider.RelationsHospital@MolinaHealthcare.com
East Region	Andrea Williams	OHProvider.RelationsHospital@MolinaHealthcare.com
West Region	Crysta Davis	OHProvider.RelationsHospital@MolinaHealthcare.com

Contact information for Provider Engagement Team providers or groups:

Provider Region	Representative	Email Address
All State	Sonya Adams	OHProviderServicesPET@MolinaHealthCare.Com
All State	Shard'e Stubbs	OHProviderServicesPET@MolinaHealthCare.Com

Contact information for our Provider Advisory Council (PAC):

Provider Region	Representative	Email Address
All State	William Caine	OHProviderRelations@MolinaHealthcare.com

For general inquiries, questions, or comments or to identify your specific representative:

Email Address
OHProviderRelations@MolinaHealthcare.com

Any Questions ?

MOLINA HEALTHCARE

MOLINA HEALTHCARE