Combined Provider Manual Addendum
Effective Jan. 1, 2023

Added: OhioRISE Transportation

Page 29: The following language will be added in IV. Behavioral Health, H. OhioRISE

In accordance with Appendix B of the ODM Medicaid Provider Agreement for Managed Care Organization (MCO):

- Molina will arrange and provide transportation for members who are enrolled with the OhioRISE plan in a manner that ensures children, youth, and their families served by the OhioRISE Plan do not face transportation barriers to receive services regardless of Medicaid payer.
- Molina will arrange transportation in cases where transportation of families, caregivers, and siblings (other minor residents of the home) is needed to facilitate the treatment needs of the Member. This may include transportation of a family member(s) to the facility and/or location of the Member to participate in the Member's treatment needs when the Member is not being transported themself.

Updated: Paper Claim Submission

Page 35: The following language will be updated in V. Claims and Compensation, E. Paper Claim Submissions

Existing language:

Participating Providers should submit Claims electronically. If electronic Claim submission is not possible, please submit paper Claims to the following address:

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

Please keep the following in mind when submitting paper Claims:

- Paper Claims should be submitted on original red colored CMS-1500 Claim forms.
- Paper Claims must be printed, using black ink.

New language:

Participating Providers should submit Claims electronically. If electronic Claim submission is not possible, please submit paper Claims to the following address:

Molina Healthcare of Ohio Inc.
P.O. Box 22712

Long Beach, CA 90801

When submitting paper Claims:

- Paper Claim submissions are not considered to be "accepted" until received at the appropriate Claims PO Box; Claims received outside of the designated PO Box will be returned for appropriate submission.
- Paper Claims are **required** to be submitted on original red and white CMS-1500 and CMS-1450 (UB-04) Claim forms.
- Paper Claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms, and any altering to include Claims with handwriting.
- Claims must be typed with either 10 or 12 point Times New Roman font, using black ink.
- Link to paper Claims submission guidance from CMS: cms.gov/Medicare/Billing/ElectronicBillingEDITrans/1500

Note: Upon implementation of Phase 3 of the Next Generation Medicaid Program, paper claims will no longer be accepted for the Medicaid line of business.

Updated: Electronic Claim Payment

Page 55: The following language will be updated in V. Claims and Compensation, Z. Electronic Claim Payment

Molina's contracted vendor, Change Healthcare, will be sunsetting their ProviderNet portal as of Jan. 1, 2023. If a provider or providers clearinghouse were accessing 835 files and Explanation of Payments from this portal for payments issued prior to Molina's migration to ECHO Health portal, they will no longer have access to these documents through ProviderNet and will need to request them from Molina (for 835's) or access the Explanation of Payments through the Availity Essentials Portal.

What do providers need to do?

- Before Jan. 1, 2023, please log in to ProviderNet and download all 835 files, Explanation of Payments, and capitation summary documents you may be missing.
- After ProviderNet has been sunset, if you require historical 835 files, Explanation of Payments, or capitation support, please contact Molina at (855) 322-4079.
- When you contact Molina regarding 835 requests, please be sure to include the information below that will be required to send the files via Secure File Transfer Protocol (SFTP) to you or your clearinghouse. Please note these requests can take 10-14 business days to complete.
    - SFTP destination location for the 835's should be delivered to.
    - Be ready to provide an IP address if Molina does not have your SFTP information on record.

Existing language:

Z. Electronic Claim Payment

Participating Providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, provides searchable ERAs, and Providers receive payment and ERA access faster than the paper check and Remittance Advice (RA) processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at MolinaHealthcare.com/OhioProviders under the EDI ERA/EFT tab or by contacting our Provider Services Department.

ProviderNet

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

Registration is easy. Follow these simple steps:

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

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

If you have any questions regarding the actual registration process, please contact ProviderNet customer service at (877) 389-1160 or email wco.provider.registration@changehealthcare.com.

New language:

Z. Electronic Payment Requirements

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

Molina contracts with our payment vendor, Change Healthcare, who has partnered with ECHO Health, Inc. (ECHO), for payment delivery and 835 processing. On this platform you may receive your payment via EFT/ACH, a physical check, or a virtual card.

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

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

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

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

As a reminder, Molina's Payer ID is 20149.

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

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

Updated: Anti-Kickback Statute

Page 153: The following language will be updated in XIII. Compliance, A. Fraud, Waste, and Abuse, Regulatory Requirements, Anti-Kickback Statute

Existing language:

- **Anti-Kickback Statute** – Provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable or reimbursable under the Medicare or other federal health care programs.

New language:

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

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

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

What is AKS?

AKS statutes and regulations prohibit paying or receiving anything of value to induce or reward patient referrals or the generation of business involving any item or service payable by Federal and State health care programs. The phrase "anything of value" can mean cash, discounts, gifts,

excessive compensation, contracts not at fair market value, etc. Examples of prohibited AKS actions include a health care Provider who is compensated based on patient volume, or a Provider who offers remuneration to patients to influence them to use their services.

Under Molina's policies, Providers may not offer, solicit an offer, provide, or receive items of value of any kind that are intended to induce referrals of Federal health care program business. Providers must not, directly, or indirectly, make or offer items of value to any third party, for the purpose of obtaining, retaining, or directing our business. This includes giving, favors, preferential hiring, or anything of value to any government official.

Marketing Guidelines and Requirements

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

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

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

Updated: Provider Data Accuracy and Validation

Page 176: The following language will be updated in XVI. Provider Responsibilities, D. Provider Data Accuracy and Validation

Existing language:

D. Provider Data Accuracy and Validation

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

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

Providers must validate the Provider Online Directory (POD) information at least quarterly for correctness and completeness. Providers must notify Molina in writing (some changes can be made online) as soon as possible, but no less than 30 calendar days in advance of changes such as, but not limited to:

- Change in office location(s), office hours, phone, fax, or email.
- Addition or closure of office location(s).
- Addition or removal of a Provider (within an existing clinic/practice).
- Change in practice name, Tax ID and/or National Provider Identifier (NPI).
- Opening or closing the practice to new patients (PCPs only – see section on Provider Panel for further details).
- Any other information that may impact Member access to care.

Please visit our Provider Online Directory at MolinaHealthcare.com MolinaHealthcare.com/ProviderSearch to validate your information. For corrections and updates, a convenient Provider Information Update Form can be found on the Provider Website. You can also notify your Provider Services Team or complete the Provider Information Update Form found on our Provider website under the "Forms" tab if your information needs to be updated or corrected.

Note: For Community Behavioral Health Organizations (Provider types 84 & 95), any additions, removals and changes/updates for employed rendering Providers (including specialty and degree changes) are to be submitted directly to ODM through the MITS system. ODM will then provide this information to Molina to update our systems. Please note that all agency-level updates are to be submitted directly to Molina using the options described in the previous paragraph.

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

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

New language:

D. Provider Data Accuracy and Validation

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

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

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

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

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

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

Please visit our Provider Online Directory to validate your information. Providers can make updates through the CAQH portal. Providers unable to make updates through the CAQH portal should contact their Provider Services Representative for assistance.

Note: At a future date in 2023, the ODM Provider Network Management (PNM) system will become the source of truth for ODM and Managed Care Organizations' provider data.

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

National Plan and Provider Enumeration System (NPPES) Data Verification

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

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

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

Provider Manual

Molina Healthcare of Ohio, Inc. (Molina Healthcare or Molina)

Medicaid and MyCare Ohio

January 2023

The Provider Manual is customarily updated annually but may be updated more frequently as policies or regulatory requirements change. Providers can access the most current Provider Manual at MolinaHealthcare.com/OhioProviders.

Last Updated: 11/2022

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

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

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

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

Table of Contents

I. Contact Information

Molina Healthcare of Ohio
3000 Corporate Exchange Drive
Columbus, Ohio 43231

Provider Services Department

The Provider Services Department handles telephone and written inquiries from Providers regarding address and Tax Identification (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 Provider Portal.

Phone: (855) 322-4079
Fax: (888) 296-7851

Member Services Department

The Member Services Department handles all telephone and written inquiries regarding Member Claims, benefits, eligibility/identification, Pharmacy inquiries, selecting or changing Primary Care Providers (PCPs), and Member complaints. Member Services Representatives are available Monday through Friday from 8 a.m. to 6 p.m. for Molina Dual Options MyCare Ohio or 8 a.m. to 5 p.m. for all other lines of business, excluding holidays and the Day after Thanksgiving. Eligibility verifications can be conducted at your convenience via the Provider Portal.

Phone:

- Medicaid: (800) 642-4168
- MyCare Ohio, Dual Options Medicare Medicaid Plan: (855) 665-4623
- MyCare Ohio, Dual Options Medicaid Plan: (855) 687-7862
- TTY/TDD: 711

Claims Department

Molina strongly encourages participating Providers to submit Claims electronically (via a clearinghouse or the Provider Portal) whenever possible.

- Access the Provider Portal at (provider.MolinaHealthcare.com)
- EDI Payer ID 20149

To verify the status of your Claims, please use the Provider Portal. For other Claims questions contact Provider Services.

Claims Recovery Department

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

Please direct payment and any correspondence to:
Molina Healthcare of Ohio
Dept. 781661 P.O. Box 78000
Detroit, MI 48278-1661

If returning a Molina Healthcare check, please send to:
Molina Healthcare of Ohio
P.O. Box 349020
Columbus, OH 43234-9020

Phone: (866) 642-8999

Compliance and Fraud AlertLine

If you suspect cases of fraud, waste, or abuse, you must report it to Molina. You may do so by contacting the Molina AlertLine or submit an electronic complaint using the website listed below. For more information about fraud, waste, and abuse, please see the Compliance section of this Provider Manual.

Molina Healthcare of Ohio
Attn: Compliance
P.O. Box 349020
3000 Corporate Exchange Drive
Columbus, OH 43234

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

Credentialing Department

The Credentialing Department verifies all information on the Provider Application prior to contracting and reverifies this information every three years, or sooner, depending on Molina's Credentialing criteria. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Molina network.

Molina Healthcare of Ohio, Inc.
Attention: Credentialing Director
P.O. Box 2470
Spokane, WA 99210

Phone: (855) 322-4079

Nurse Advice Line

This telephone-based nurse advice line is available to all Molina Members. Members may call anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, seven days a week, 365 days a year to assess symptoms and help make good health care decisions.

English Phone: (888) 275-8750
Spanish Phone: (866) 648-3537
English TTY/TDD: (866) 735-2929
Spanish TTY/TDD: (866) 833-4703
TTY/TDD: 711 Relay

Health Care Services Department

The Health Care Services (formerly Utilization Management) Department conducts concurrent review on inpatient cases and processes Prior Authorizations/Service Requests. The Health Care Services (HCS) Department also performs Care Management for Members who will benefit from Care Management services. Participating Providers are required to interact with Molina's HCS Department electronically whenever possible. Prior Authorizations/Service Requests and status checks can be easily managed electronically.

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

- Easy to access 24/7 online submission and status checks.
- Ensures Health Insurance Portability and Accountability Act (HIPAA) compliance.
- Ability to receive real-time authorization status.
- Ability to upload medical records.
- Increased efficiencies through reduced telephonic interactions.
- Reduces cost associated with fax and telephonic interactions.

Molina offers the following electronic Prior Authorizations/Service Requests submission options:

- Submit requests directly to Molina via the Provider Portal. See the Provider Portal Quick Reference Guide or contact your Provider Services Team for registration and submission guidance.
- Submit requests via 278 transactions. See the Electronic Data Interchange (EDI) transaction section of Molina's Provider Website for guidance.

Provider Portal: provider.MolinaHealthcare.com
Phone: (855) 322-4079
Fax:

- Medicaid/MyCare Ohio Medicaid Only: (866) 449-6843

- Molina Medicare/MyCare Ohio Medicare Medicaid
  - Inpatient: (877) 708-2116
  - Home Health: (844) 251-1451
  - Outpatient: (844) 251-1450
- Advanced Imaging: (877) 731-7218

Health Management

Molina's Health Management Programs will be incorporated into the Member's treatment plan to address the Member's health care needs.

Phone: (855) 322-4079

Weight Management and Smoking Cessation Programs

Phone: (866) 472-9483
Fax: (562) 901-1176

Health Management Programs

Phone: (866) 891-2320
Fax: (800) 642-3691

Behavioral Health

Molina manages all components of Covered Services for behavioral health for adult members and for child and youth members who are not enrolled in the OhioRISE program. For Member behavioral health needs, please contact us directly at (855) 322-4079. Molina has a Behavioral Health Crisis Line that Members may access 24 hours per day, 365 days per year by calling the Member Services number on the back of their Molina ID card.

Aetna Better Health of Ohio, the OhioRISE Plan

OhioRISE is a specialized Medicaid managed care program that focuses on children and youth who have complex behavioral health and multisystem needs. For more information and resources visit aetnabetterhealth.com/ohiorise

Pharmacy Department

Prescription drugs are covered through CVS Caremark. A list of in-network pharmacies is available on the MolinaHealthcare.com website or by contacting Molina.

Phone: (855) 322-4079
Prior Authorization Fax: (800) 961-5160

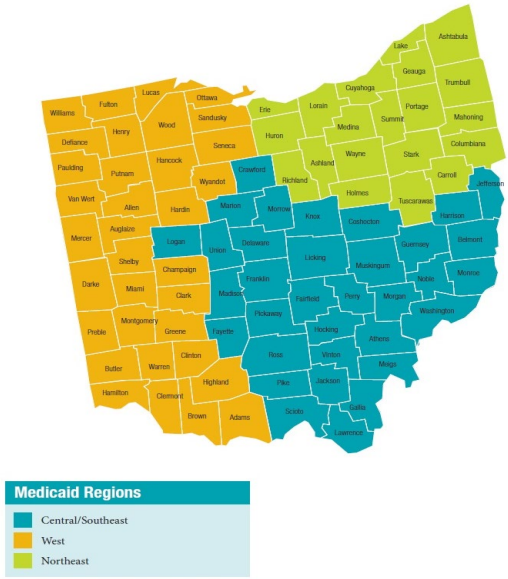
Quality Improvement

Molina maintains a Quality Improvement (QI) Department to work with Members and Providers in administering the Molina Quality Program.

Phone: (855) 322-4079

Molina Healthcare of Ohio, Inc. Service Area

Medicaid:



MyCare Ohio:

II. Enrollment, Eligibility, Disenrollment

A. Enrollment

Enrollment in Medicaid Programs

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

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

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

To qualify for Medicaid, a person must meet basic requirements:
- Be a U.S. citizen or meet Medicaid citizenship requirements.
- Be an Ohio resident.
- Have or get a social security number.
- Meet financial requirements.

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

Ohio has Medicaid programs for three different populations:

1. Covered Families and Children (CFC)
   - Healthy Families
     - Children up to age 19
     - Pregnant Member
     - Families with children under age 19
2. Aged, Blind or Disabled (ABD)
   - Age 65 or older
   - Legally blind
   - Disabled (as classified by the Social Security Administration)
3. Adult Extension (AEP)
   - Adults between the ages of 19 to 64, who are between 0 to 138 percent of the Federal Poverty Level (FPL)
   - Are not eligible under another category of Medicaid

- Parents who are between 91 to 138 percent of the Federal Poverty Level (FPL) are eligible

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

- To enroll in the MCP of their choice, consumers must call the Medicaid Consumer Hotline at (800) 324-8680, TTY (800) 292-3572 or visit the Medicaid Consumer Hotline website at ohiomh.com.
- Consumers who do not make a selection will be automatically enrolled in an MCP.
- Consumers may change their MCP for any reason within the first three months of their initial selection.

After the first three months, consumers must wait until the Open Enrollment Period to change MCPs. A Just Cause request can be filed at any time to change MPCs. The Ohio Department of Medicaid will review the circumstances and approve or deny the Just Cause request.

OhioRISE Eligibility:

- Enrolled in Ohio Medicaid – either managed care or fee-for-service
- Be twenty years of age or younger at the time of enrollment
- Meet a functional needs threshold for behavioral health care, as identified by the Child and Adolescent Needs and Strengths (CANS) assessment tool, or the following:
  - An inpatient in a hospital with a primary diagnosis of mental illness or substance use disorder;
  - An inpatient in a psychiatric residential treatment facility (PRTF)
- Not be enrolled in a MyCare Ohio plan as described in Chapter 5160-58 of the Administrative Code

Enrollment in Molina Dual Options MyCare Ohio Medicare-Medicaid Plan

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

- Age 18 or older at the time of enrollment.
- Entitled to benefits under Medicare Part A, and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits.
- Individuals eligible for full Medicaid per the spousal impoverishment rule codified at section 1924 of the Social Security Act.

- Reside in the applicable MyCare Ohio demonstration counties: Franklin, Delaware, Union, Madison, Pickaway, Clark, Greene, Montgomery, Clinton, Warren, Butler, Hamilton and Clermont.
- Molina Dual Options will accept all Members who meet the above criteria and elect to join the Molina Dual Options plan during appropriate enrollment periods.
- Member or Member's legal representative completes an enrollment election form completely and accurately.
- Is fully informed and agrees to abide by the rules of Molina Dual Options;
- The Member makes a valid enrollment request that is received by the plan during an election period.
- For Molina Dual Options: Is entitled to Medicaid benefits as defined by the State of Ohio.

Furthermore, Molina does not impose any additional eligibility requirements as a condition of enrollment other than those established by CMS in Chapter 2 of the Medicare Managed Care Manual.

Managed Care Plan Exclusions

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

A Member has the option not to participate in a managed care plan if:
- The Member is part of a federally recognized Indian tribe, regardless of age.
- The Member receives home and community-based waiver services through the Ohio Department of Developmental Disabilities.

Exclusions - Individuals that are not permitted to join a Medicaid MCP:
- Dually eligible under both the Medicaid and Medicare programs (not including MyCare Ohio eligible Members who must enroll in an MCP).
- Institutionalized (in a nursing home and are not eligible under the Adult Extension category, long-term care facility, Intermediate Care Facilities for Individuals with Developmental Disabilities [ICF-MR], or some other kind of institution).
- Receiving Medicaid Waiver services and are not eligible under the Adult Extension category.

Note: A Member who is eligible for Medicaid under the Adult Extension category will receive nursing home services through the Managed Care Plan. Additionally, Adult Extension Members approved for waiver services will remain in the MCP.

Member Toll-Free Telephone Numbers:

Members may call our Member Services Department toll free at:
- Medicaid: (800) 642-4168 from 7 a.m. to 7 p.m., Monday to Friday
- MyCare Ohio Dual Options Medicare Medicaid Plan: (855) 665-4623 from 8 a.m. to 8 p.m., Monday to Friday

- MyCare Ohio Dual Options Medicaid Only Plan (855) 687-7862 from 8 a.m. to 8 p.m., Monday to Friday
- TTY/TDD 711, for persons with hearing impairments.

Effective Date of Enrollment

The Member effective date is determined by ODM and CMS and passed to Molina on the ODM eligibility file.

Newborn Coverage for Medicaid

If a Member has active Medicaid coverage in one of the below categories upon the birth date of the baby, the newborn is eligible for Molina membership from their date of birth:

- Healthy Families Covered Families and Children (CFC)
- Adult Expansion (AEP)
- Aged, Blind and Disabled (ABD)

Exceptions are Members: who are in the MyCare Ohio Program, in the custody of a Protective Children's Services Agency (PCSA) or who are receiving an adoption assistance subsidy. These three exceptions are excluded from this process.

Inpatient at Time of Enrollment

Regardless of what program or health plan the Member is enrolled in at discharge, the program or plan the Member was enrolled with on the date of admission shall be responsible for payment of all covered inpatient facility services provided from the date of admission until the date the Member is no longer confined to an acute care hospital. Professional service fees will be the responsibility of the managed care plan the Member is enrolled with at the time. If a Member loses Medicaid coverage during inpatient status, the program or plan the Member was enrolled with on the date of admission shall only be responsible for payment of all covered inpatient facility services until the Member's Medicaid eligibility termination date.

Eligibility Verification

The State of Ohio determines eligibility for the Medicaid program. Payment for services rendered is based on eligibility and benefit entitlement. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

To ensure payment, Molina strongly encourages Providers to verify eligibility at every visit and especially prior to providing services that require authorization. Possession of the ID card does not guarantee Member eligibility or coverage. It is the responsibility of the Provider to verify the eligibility of the cardholder.

Eligibility Listing for Medicaid Programs

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

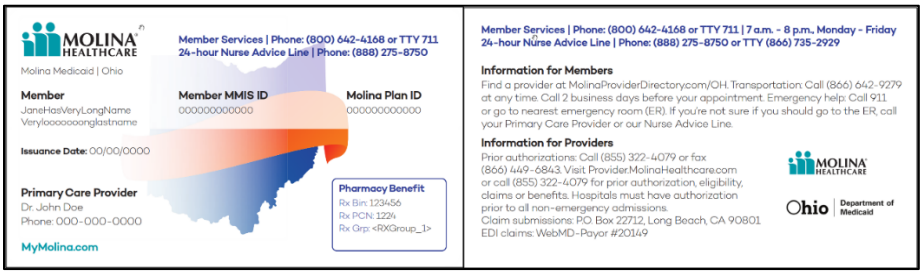
1. Log on to MolinaHealthcare.com/OhioProviders and log in to the Provider Portal.
2. Call Provider Services at:
   - Medicaid: (855) 322-4079, Monday through Friday from 8 a.m. to 5 p.m.
   - Molina MyCare Ohio Dual Options Medicare-Medicaid Plan: (855) 322-4079, Monday through Friday from 8 a.m. to 6 p.m.
   - Molina MyCare Ohio Medicaid Only: (855) 322-4079, Monday through Friday from 8 a.m. to 6 p.m.
3. Check your current eligibility roster.
4. Medicaid Providers can call the ODM Interactive Voice Response (IVR) System 24 hours a day, seven days a week, 365 days a year to confirm eligibility for MCP or Fee-for-Service Medicaid consumers. Providers must have a PIN number to access this information.

Possession of a Medicaid ID Card does not mean an individual is eligible for Medicaid services. A Provider should verify a recipient's eligibility each time the recipient receives services. The Provider Portal, Provider Services Contact Center or the Ohio Department of Medicaid's Information Technology System (MITS) can be used to verify a recipient's enrollment in a managed care plan.

B. Identification Cards

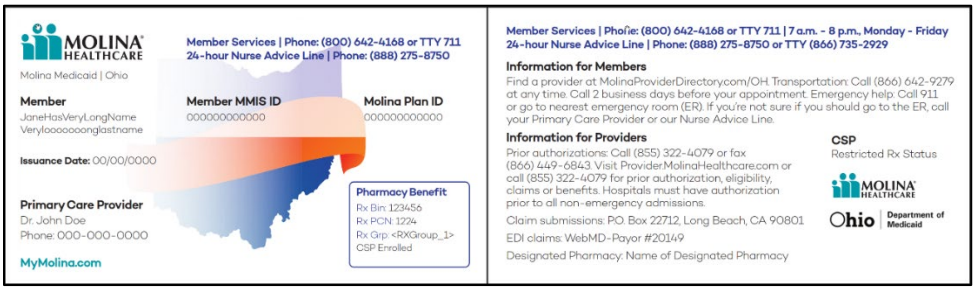
Molina Sample Member ID Cards

Molina Healthcare Medicaid Standard Member ID Card



Molina Healthcare Medicaid Coordinated Services Program (CSP) Full Lock-In Member ID Card

Molina Healthcare Medicaid CSP Partial Lock-In Member ID Card

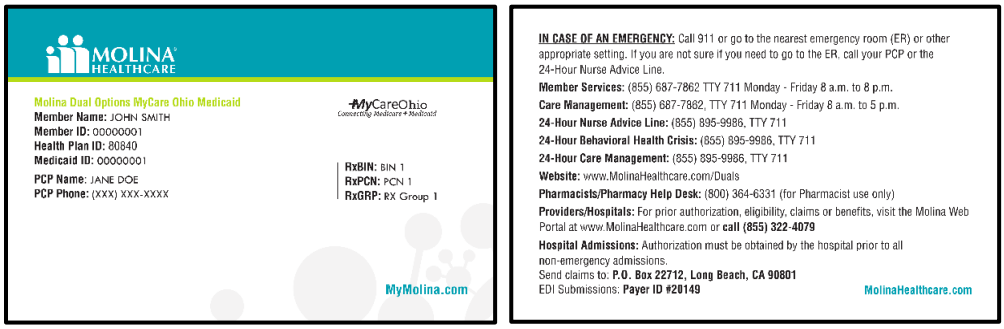


Molina Healthcare Medicaid OhioRISE Member ID Card

Molina Healthcare Medicaid OhioRISE with CSP Full Lock-In Member ID Card

Molina Healthcare Medicaid OhioRISE with CSP Partial Lock-In Member ID Card

Molina MyCare Ohio Medicaid only (opt-out)



Molina Dual Options MyCare Ohio (full benefits)

Members are reminded in their Member Handbooks to carry their Molina ID cards with them when requesting medical or pharmacy services. It is the Provider's responsibility to ensure Molina Members are eligible for benefits prior to rendering services. Unless an emergency medical condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

C. Disenrollment

Voluntary Disenrollment

Medicaid Disenrollment

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

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

Additional information regarding disenrollment and Transition of Care can be found in Appendix B.

Molina Dual Options MyCare Ohio Disenrollment

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

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

Molina Dual Options will refer the Member to ODM (or their designated vendor) to process disenrollment of Members from the health plan only as allowed by Centers of Medicare & Medicaid Services (CMS) regulations. Molina Dual Options may request that a Member be disenrolled under the following circumstances:

- Member requests disenrollment.
- Member enrolls in another plan (during a valid enrollment period);
- Member leaves the service area and directly notifies Molina of the permanent change of residence;
- Member loses entitlement to Medicare Part A or Part B benefits;
- Member loses Medicaid eligibility;
- Molina loses or terminates its contract with CMS. In the event of plan termination by CMS, Molina will send CMS-approved notices and a description of alternatives for obtaining benefits. The notice will be sent timely, before the termination of the plan; and/or,
- Molina discontinues offering services in specific service areas where the Member resides.

In all circumstances except death, Molina will provide a written notice to the Member with an explanation of the reason for the disenrollment. All notices will be in compliance with CMS regulations and will be approved by CMS.

Voluntary disenrollment does not preclude Members from filing a grievance with Molina for incidents occurring during the time they were covered.

Involuntary Disenrollment

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

- Fraud or misuse of the Member's Molina ID card.
- Molina Dual Options may request that a Member be disenrolled under the following circumstances:
  - Member enrolls in another plan.
  - Member has engaged in disruptive behavior, which is defined as behavior that substantially impairs the plan's ability to arrange for or provide services to the individual or other plan Members.
    - An individual cannot be considered disruptive if such behavior is related to the use of medical services or compliance (or noncompliance) with medical advice or treatment.

Molina will send three written notices to the Beneficiary including:

- an explanation of the disruptive conduct and its impact on the Integrated Care Delivery System (ICDS) Plan's ability to provide services.
- examples of the types of reasonable accommodations the ICDS Plan has already offered.
- the Grievance procedures.
- an explanation of the availability of other accommodations.

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

- Member abuses the identification card by allowing others to use it to fraudulently obtain services.
- Member has not permanently moved but has been out of the service area for six months or more.
- Molina Dual Options loses or terminates its contract with CMS:
  - In the event of plan termination by CMS, Molina Dual Options will send CMS-approved notices and a description of alternatives for obtaining benefits.
  - The notice will be sent timely, before the termination of the plan.
- Molina Dual Options discontinues offering services in specific service areas where the Member resides.

When Members permanently move out of Molina's service area or leave Molina's service area for more than six consecutive months, they must disenroll from Molina's programs. There are a number of ways that the Molina Enrollment Accounting Department may be informed that the Member has relocated:

- Out-of-area notification received from ODM and forwarded to CMS on the monthly membership report.
- Through the CMS daily transaction reply report (DTRR) file (confirms that the Member has dis-enrolled).
- The Member may call to advise Molina Dual Options that they have relocated, and Molina will direct the Member to ODM for formal notification.
- Other means of notification may be made through the Claims department, if out-of-area Claims are received with a residential address other than the one on file. (Molina does not offer a visitor/traveler program to Members).

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

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

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

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

D. Primary Care Provider (PCP) Assignment

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

E. PCP Changes (ABD/CFC/AEP and Molina Dual Options MyCare Ohio Full Benefits Members only)

If for any reason a Member wants to change PCPs, they must call Member Services to ask for the change. PCP changes are permitted every 30 days, if needed. If Molina assigned the Member to the PCP and the Member calls within the first month of membership with Molina,

the change will be effective the day of the call. Molina will send the Member something in writing that say who the PCP is by the date of the change. PCP changes completed by the 15th of the month will have a start date of the first day of the second following month (i.e., a change made on January 16 will have an effective date of March 1). A new ID card is sent to the Member when a PCP change is made.

III. Benefits and Covered Services

This section provides an overview of the medical benefits and Covered Services for Molina Members. Some benefits may have limitations. If there are questions as to whether a service is covered or requires Prior Authorization, please contact Molina at (855) 322-4079 Monday through Friday from 8 a.m. to 6 p.m. for Molina Dual Options MyCare Ohio or 8 a.m. to 5 p.m. for all other lines of business.

Molina ensures that Medicaid Members have access to medically-necessary services covered by the Ohio Medicaid Fee-for-Service (FFS) program. Molina Dual Options Members will have access to all medically-necessary services covered by CMS and the Ohio Medicaid FFS program. This includes managed long-term services and supports (MLTSS), community behavioral health, and services provided in a Skilled Nursing Facility (SNF). For information on Medicaid-Covered Services, refer to the Ohio Department of Medicaid (ODM) website at: medicaid.ohio.gov/wps/portal/gov/medicaid/families-and-individuals/srvcs/services.

A. Member Cost Sharing

Cost Sharing is the Deductible, Copayment or Coinsurance that Members must pay for Covered Services provided under their Molina plan. Additional detail regarding cost sharing listed in the Summary of Benefits.

It is the Provider's responsibility to collect the copayment and other Member Cost Share from the Member to receive full reimbursement for a service. The amount of the copayment and other Cost Sharing will be deducted from the Molina payment for all Claims involving Cost Sharing.

B. Services Covered by Molina

Molina covers the services described in the Summary of Benefits documentation. If there are questions as to whether a service is covered or requires prior authorization, please contact Molina at (855) 322-4079 Monday through Friday from 8 a.m. to 6 p.m. for Molina Dual Options MyCare Ohio or 8 a.m. to 5 p.m. for all other lines of business.

C. Link(s) to Molina Benefit Materials

Member benefit materials include the Summary of Benefits which can be found on Molina's website. Link(s):

- Medicaid offered by Molina in Ohio at MolinaHealthcare.com/members/oh/en-us/-/media/Molina/PublicWebsite/PDF/members/oh/en-us/Medicaid/benefits-at-a-glance.pdf.
- Molina Dual Options MyCare Ohio offered by Molina in Ohio at MolinaHealthcare.com/members/oh/en-us/mem/mycare/duals/coverd/benefits.aspx.
- Molina MyCare Ohio Medicaid Only offered by Molina in Ohio at MolinaHealthcare.com/members/oh/en-us/mem/mycare/optout/coverd/benefits.aspx.

Detailed information about benefits and services can be found in the Member Handbook, available on the Member Website.

D. Obtaining Access to Certain Covered Services

Non-Preferred Drug Exception Request Process

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

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

Specialty Drug Services

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

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

Injectable and Infusion Services

Many self-administered and office-administered injectable products require Prior Authorization (PA). In some cases, they will be made available through a vendor, designated by Molina. More information about our Prior Authorization process, including a link to the PA request form, is available in the Pharmacy section of this Provider Manual.

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

Access to Behavioral Health Services

Members in need of behavioral health services can be referred by their PCP for services or Members can self-refer by calling Molina's Behavioral Health Department by calling Molina Member Services at (855) 322-4079 and asking for the Behavioral Health Team. Molina's Nurse Advice Line is available 24 hours a day, seven days a week, 365 days a year for mental health or substance abuse needs. The services Members receive will be confidential. Additional detail regarding Covered Services and any limitations can be obtained in the Summary of Benefits linked above, or by contacting Molina.

Emergency Mental Health or Substance Abuse Services

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

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

Out-of-Area Emergencies

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

- Go to the nearest emergency room.
- Call the number on Member 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.

Emergency Transportation

When a Member's condition is life-threatening and requires use of special equipment, life support systems and close monitoring by trained attendants while en route to the nearest

appropriate facility, emergency transportation is thus required. Emergency transportation includes, but is not limited to, ambulance, air or boat transports.

Non-Emergency Medical Transportation

For Molina Members who have non-emergency medical transportation as a Covered Service, Molina covers transportation to medical facilities when the Member's medical and physical condition does not allow them to take regular means of public or private transportation (car, bus, etc.). Examples of non-emergency medical transportation include, but are not limited to, lifter vans and wheelchair accessible vans. Members must have Prior Authorization from Molina for air ambulance services before the services are given. Prior Authorization not required for vans, taxi, etc. Additional information regarding the availability of this benefit is available by contacting Provider Services at (855) 322-4079.

Preventive Care

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

MolinaHealthcare.com/providers/oh/medicaid/resource/guide_prevent.aspx

Molina needs your help conducting these regular exams in order to meet the targeted state and federal standards. If you have questions or suggestions related to preventive care, please call our Health Education line at (866) 472-9483.

Immunizations

Adult Members may receive immunizations as recommended by the Centers for Disease Control and Prevention (CDC) and prescribed by the Member's PCP. Child Members may receive immunizations in accordance with the recommendations of the American Academy of Pediatrics (AAP) and prescribed by the child's PCP.

Immunization schedule recommendations from the AAP and/or the CDC are available at the following website: cdc.gov/vaccines/schedules/hcp/index.html.

Molina covers immunizations not covered through Vaccines for Children (VFC).

Well Child Visits and EPSDT Guidelines

The Federal Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit requires the provision of early and periodic screening services and well care examinations to individuals from birth until 21 years of age, with diagnosis and treatment of any health or behavioral health problems identified during these exams. The standards and periodicity schedule generally follow the recommendations from the AAP and Bright Futures.

The screening services include:

- Comprehensive health and developmental history (including assessment of both physical and mental health development)
- Immunizations in accordance with the most current Advisory Committee on Immunization Practices (ACIP) schedule for pediatric vaccines
- Comprehensive unclothed physical exam
- Laboratory tests as specified by the AAP, including screening for lead poisoning
- Health education
- Vision services
- Hearing services
- Dental services

When a screening examination indicates the need for further evaluation, Providers must provide diagnostic services or refer Members when appropriate without delay. Providers must provide treatment or other measures (or refer when appropriate) to correct or ameliorate defects and physical and behavioral health conditions discovered by the screening services.

Molina needs your help conducting these regular exams in order to meet the targeted state standard. Providers must use correct coding guidelines to ensure accurate reporting for EPSDT services. If you have questions or suggestions related to EPSDT or well child care, please call our Health Education line at (866) 472-9483.

Prenatal Care

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

Emergency Services

Emergency Services means: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant Member, the health of the Member or their unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergent and urgent care Services are covered by Molina without an authorization. This includes non-contracted Providers inside or outside of Molina's service area.

Nurse Advice Line

Members may call the Nurse Advice Line any time they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, seven days a week, 365 days a year to assess symptoms and help make good health care decisions.

English Phone: (888) 275-8750
Spanish Phone: (866) 648-3537
TTY/TDD: 711 Relay

The registered nurses who staff the Nurse Advise Line do not diagnose. They assess symptoms and guide the patient to the most appropriate level of care (LOC) following specially designed algorithms unique to the Nurse Advice Line. The Nurse Advice Line may refer back to the PCP, a specialist, 911 or the Emergency Room. By educating Members, it reduces costs and over utilization on the health care system.

Molina is committed to helping our Members:
- Prudently use the services of your office.
- Understand how to handle routine health problems at home.
- Avoid making non-emergent visits to the emergency room (ER)

E. Health Management Programs

Health Management

The tools and services described here are educational support for Molina Members and may be changed at any time as necessary to meet the needs of Molina Members.

Health Education/Disease Management

Molina offers programs to help our Members and their families manage various health conditions. The programs include telephonic outreach from our clinical staff and health educators along with access to educational materials. You can refer Members who may benefit from the additional education and support Molina offers. Members can request to be enrolled or disenrolled in these programs at any time. Our programs include:
- Asthma management
- Diabetes management
- High blood pressure management
- Heart Failure
- Chronic Obstructive Pulmonary Disease (COPD) management
- Depression management
- Obesity
- Weight Management
- Smoking Cessation
- Organ Transplant
- Serious and Persistent Mental Illness (SPMI) and Substance Use Disorder

- Maternity Screening and High-Risk Obstetrics

For more information about these programs, please call (866) 472-9483 (TTY/TDD at 711 Relay).

F. Telehealth and Telemedicine Services

Molina Members may obtain Covered Services by participating Providers, through the use of Telehealth and Telemedicine services. Not all participating Providers offer these services. The following additional provisions apply to the use of Telehealth and Telemedicine services:

- Services must be obtained from a participating Provider.
- Services are meant to be used when care is needed now for non-emergency medical issues.
- Services are a method of accessing Covered Services, and not a separate benefit.
- Services are not permitted when the Member and participating Provider are in the same physical location.
- Services do not include texting, facsimile or email only.
- Services include preventive and/or other routine or consultative visits during a pandemic.
- Member cost sharing associated to the Schedule of Benefits based upon the participating Provider's designation for Covered Services (i.e., Primary Care, Specialist or other Practitioner).
- Covered Services provided through store-and-forward technology, must include an in-person office visit to determine diagnosis or treatment.

Upon at least 10 days' prior notice to Provider, Molina shall further have the right to a demonstration and testing of Provider telehealth service platform and operations. This demonstration may be conducted either virtually or face-to-face, as appropriate for telehealth capabilities and according to the preference of Molina. Provider shall make its personnel reasonably available to answer questions from Molina regarding telehealth operations.

For additional information on Telehealth and Telemedicine Claims and billing, please refer to the Claims and Compensation section of this Provider Manual.

For detailed information on the benefits and Covered Services, please refer to Appendix A.

G. Supplemental Services

A referral from the Member's PCP is not required for mandatory supplemental benefits.

Please refer to the Member Summary of Benefits for more information – a link is available above under "Links to Benefit Materials."

Molina partners with Providers/vendors for certain services. To find an in-network Provider/vendor, please refer to the Provider Online Directory on Molina's website at MolinaHealthcare.com.

H. Provider Education on Covered Benefits and Member Access to Care

Providers are educated on the tools and information required to ensure Members understand their benefits and how to access care. This includes but is not limited to:

- How to identify MyCare Ohio and Medicaid Covered Benefits by accessing the appropriate plan or state agency materials.
- How to access Medicaid Covered Services including waiver services such as MLTSS, In-Home Supportive Services (IHSS), or Behavioral Services.

IV. Behavioral Health

A. Overview

Molina provides a behavioral health benefit for Members **who are not enrolled in the OhioRISE program**. Molina takes an integrated, collaborative approach to behavioral health care, encouraging participation from PCPs, behavioral health, and other specialty care Providers to ensure whole person care. All provisions within the Provider Manual are applicable to medical and behavioral health Providers unless otherwise noted in this section.

B. Utilization Management and Prior Authorization

Behavioral health inpatient and residential services can be requested by submitting a Prior Authorization form or contacting Molina's at (855) 322-4079. Providers requesting after-hours authorization for these services should utilize Provider Portal or fax submission options. Emergency psychiatric services do not require Prior Authorization. All requests for behavioral health services should include the most current version of Diagnostic and Statistical Manual of Mental Disorders (DSM) classification. Molina utilizes standard, generally accepted Medical Necessity criteria for Prior Authorization reviews. Please see the Prior Authorization subsection found in the Health Care Services section of this Provider Manual for additional information.

C. Access to Behavioral Health Providers and PCPs

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

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

D. Care Coordination and Continuity of Care

Discharge Planning

Discharge planning begins upon admission to an inpatient or residential behavioral health facility. Members who were admitted to an inpatient or residential behavioral health setting must have an adequate outpatient follow-up appointment scheduled with a behavioral health Provider prior to discharge.

Interdisciplinary Care Coordination

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

Care Management

Molina's Care Management team includes licensed nurses and clinicians with behavioral health experience to support Members with mental health and Substance Use Disorder (SUD) needs. Members with high-risk psychiatric, medical or psychosocial needs may be referred by a behavioral health Provider to the Care Management Program.

Referrals to the Care Management Program may be made by contacting Molina at:

Phone: (855) 322-4079, from 8 a.m. to 5 p.m., Monday through Friday

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

E. Responsibilities of Behavioral Health Providers

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

Providers shall follow Quality Access to Care standards. Molina provides oversight of Providers to ensure Members are able to obtain needed health services within the acceptable

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

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

F. Behavioral Health Crisis Lines

Molina has a Behavioral Health Crisis Line that may be accessed by Members 24 hours a day, 7 days a week, 365 days a year. The Molina Behavioral Health Crisis Line is staffed by behavioral health clinicians to provide urgent crisis intervention, emergent referrals and/or triage to appropriate supports, resources, and emergency response teams. Members experiencing psychological distress may access the Behavioral Health Crisis Line by calling the Member Services telephone number listed on the back of their Molina Member ID card.

G. Behavioral Health Tool Kit for Providers

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

H. OhioRISE

In addition to the behavioral health services provided through chapter 5160-27 of the Administrative Code, the following new services available through OhioRISE include:

- Care Coordination at three different levels:
  - Tier 1: Limited Care Coordination (LCC) delivered by Aetna for youth needing lower intensity care coordination
  - Tier 2: Moderate Care Coordination (MCC) will be consistent with principles of High-Fidelity Wraparound and will be delivered by a CME - qualified agency for youth with moderate behavioral health needs
  - Tier 3: Intensive Care Coordination (ICC) will be consistent with principles of High-Fidelity Wraparound and will be delivered by a CME - qualified agency for youth with the greatest behavioral health needs

- Intensive Home-Based Treatment (IHBT): OhioRISE will make changes to existing IHBT services and align with the Family First Prevention Services Act (FFPSA). As of July 1, 2022, IHBT is exclusive to OhioRISE.
- Psychiatric Residential Treatment Facility (PRTF): Available as a designation in Ohio in 2023, this service is aimed at keeping youth with the most intensive behavioral health needs in-state and closer to their families and support systems.
- Mobile Response and Stabilization Service (MRSS): provide youth in crisis and their families with immediate behavioral health services to ensure they are safe and receive necessary supports and services (this new service will also be available to children who are not enrolled in OhioRISE).
- Behavioral Health Respite: provides short-term, temporary relief to the primary caregiver(s) of an OhioRISE plan enrolled youth, to support and preserve the primary caregiving relationship.
- Flex Funds: provides services, equipment, or supplies not otherwise provided through the Medicaid state plan benefit or the OhioRISE program that address a youth's identified need as documented in the child and family- centered care plan. These are intended to enhance and supplement the array of services available to a youth enrolled on the OhioRISE program.
- For additional services available for youth enrolled in the OhioRISE waiver see Ohio Administrative Code Rule 5160-59-05.

Additional information on the OhioRISE services is available in chapter 5160-59 of the Ohio Administrative Code.

Additional information regarding who to bill for behavioral health services provided to youth who are enrolled in the OhioRISE plan is located in the OhioRISE Mixed Services Protocol on the OhioRISE website managedcare.medicaid.ohio.gov/managed-care/ohiorise/6-Community+and+Provider+Resources.

The OhioRISE *resources for community partners and Providers* website also contains helpful billing information for Providers: managedcare.medicaid.ohio.gov/managed-care/ohiorise/6-Community+and+Provider+Resources.

V. Claims and Compensation

Molina generally follows the Ohio Department of Medicaid (ODM) guidelines for Claims processing and payment for the Covered Families and Children (CFC), Adult Extension (AEP) and Aged, Blind or Disabled (ABD) programs. For Molina Dual Options MyCare Ohio, Molina generally follows CMS billing guidelines for Medicare Covered Services and ODM guidelines for non-Medicare Covered Services.

Payer ID	20149

Provider Portal	provider.MolinaHealthcare.com
Clean Claim Timely Filing: Medicaid	120 (prior to July 1, 2022) calendar days after the discharge for inpatient services or the Date of Service for outpatient services 365 (effective July 1, 2022) calendar days after the discharge for inpatient services or the Date of Service for outpatient services
Clean Claim Timely Filling: MyCare Ohio	120 calendar days after the discharge for inpatient services or the Date of Service for outpatient services

A. Electronic Claim Submission

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

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

Molina offers the following Claims submission options:

- Submit Claims directly to Molina via the Provider Portal.
- Submit Claims to Molina via your regular EDI Clearinghouse using Payer ID 20149.

Provider Portal

The Provider Portal is a no cost online platform that offers a number of Claims processing features:

- Submit Professional (CMS-1500) and Institutional (UB-04) Claims with attached files
- Correct/Void Claims
- Add attachments to previously submitted Claims
- Check Claims status
- View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
- Create and manage Claim Templates
- Create and submit a Claim Appeal with attached files

Clearinghouse

Molina uses Change Healthcare as its gateway Clearinghouse. Change Healthcare has relationships with hundreds of other Clearinghouses. Typically, Providers can continue to submit Claims to their usual Clearinghouse.

Molina accepts EDI transactions through our gateway Clearinghouse for Claims via the 837P for Professional and 837I for Institutional. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

When your Claims are filed via a Clearinghouse:

- You should receive a 999 acknowledgement from your Clearinghouse.
- You should also receive a 227CA response file with initial status of the Claims from your Clearinghouse.
- You should contact your local clearinghouse representative if you experience any problems with your transmission.
- Change Healthcare accepts all electronic Claims (837P/837I) on behalf of Molina. As a Provider, you may continue to submit Claims to your existing EDI Clearinghouse. They will forward your files to Change Healthcare.
- Providers billing Molina electronically should use **payer number 20149.**

EDI Claims Submission Issues

Providers who are experiencing EDI Submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider may email us at EDI.Claims@MolinaHealthcare.com for additional support.

HIPAA 5010 Transaction Compliance Standards Implementation

Molina accepts and issues all Electronic Data Interchange (EDI) HIPAA transactions in Version 5010 format, regulated by CMS. The 4010A1 transaction standards are no longer permitted.

Molina recommends all Providers reference the appropriate ODM Companion Guide (837I, 837P), found on the ODM Trading Partner website at medicaid.ohio.gov, to ensure all 5010 requirements are being met to avoid any unnecessary Claim rejections.

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

Billing of Not Otherwise Classified (NOC)

Billing of NOC codes with an additional description is a HIPAA 5010 requirement. The HIPAA Version 5010 implementation guide describes Non-Specific Procedure Codes as codes that may include, in their descriptor, terms such as: "Not Otherwise Classified (NOC); Unlisted; Unspecified; Unclassified; Other; Miscellaneous; Prescription Drug Generic; or Prescription Drug, Brand Name." If a procedure code containing any of these descriptor terms is billed, a corresponding description of that procedure is required; otherwise, the Claim is not HIPAA-

compliant. Note that there is no crosswalk of Non-Specific Procedure Codes with corresponding descriptions.

Detailed information regarding this requirement can be found in the 837I and 837P implementation guides (837I – 005010X223A2 and 837P – 005010X222A1). If the corresponding non-specific procedure code description is not submitted, the transaction does not comply with the implementation guide and is not, therefore, HIPAA compliant.

B. Timely Claim Filing

The Provider shall promptly submit Claims to Molina for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina and shall include all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by Provider to Molina for Medicaid within 120 calendar days (prior to July 1, 2022) and 365 (effective July 1, 2022) calendar days and for MyCare Ohio within 120 calendar days after the discharge for inpatient services or the date of service for outpatient services. If Molina is not the primary payer under coordination of benefits or third party liability, Provider must submit Claims to Molina within 90 calendar days after the final determination by the primary payer. Except as otherwise provided by law or provided by government program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment and the Provider hereby waives any right to payment.

Original Claims: Claims for Covered Services rendered to Molina Members must be received by Molina no later than the filing limitation stated in the Provider contract or within 120 calendar days (prior to July 1, 2022) and 365 calendar days (effective July 1, 2022) from the date of service(s) for Medicaid and 120 days from the date of service(s) for MyCare Ohio. Claims submitted after the filing limit will be denied.

Corrected Claims: Claims received with a correction of a previously adjudicated Claim must be received by Molina no later than 365 calendar days from the date of the remit of the Claim number that is being corrected. Effective April 1, 2018, corrected Claims must be submitted with the Molina Claim ID number from the original Claim being corrected, and with the appropriate corrected Claim indicator based on Claim form type. Claims submitted after the filing limit will be denied.

Coordination of Benefits: Claims received with explanation of benefits (EOB) from the primary carrier attached must be submitted to Molina within the greater of the above time frame or within 90 days of the date listed on the EOB from the other carrier.

The Provider may request a review for Claims denied for untimely filing by submitting justification for the delay as outlined in the Claim Reconsiderations section below. Acceptable proof of timely filing must include documentation with the following:

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

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

Refer to the Non-Contracted Provider Billing Guidelines for timely filing and Claim reconsideration requirements specific to non-participating Providers.

C. Claim Submission

Participating Providers are required to submit Claims to Molina with appropriate documentation. Providers must follow the appropriate state and CMS Provider billing guidelines. Providers must utilize electronic billing though a Clearinghouse or the Provider Portal whenever possible and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID number: 20149.

Providers must bill Molina for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility Claims, the date of discharge.

National Provider Identifier (NPI)

A valid NPI is required on all Claim submissions. Providers must report any changes in their NPI or subparts to Molina as soon as possible, not to exceed 30 calendar days from the change, with the exception of MLTSS Providers only.

Effective Jan. 1, 2018, ODM began requiring rendering practitioner NPI on Claims for:
- Independently licensed behavioral health professionals.

On July 1, 2018, ODM began requiring rendering practitioner NPI on Claims for:
- BH dependently licensed and paraprofessionals.
- Federal Qualified Health Center (FQHC).
- Rural Health Clinic (RHC).
- Occupational Health Facility (OHF).
- Accredited Health Care Clinic (AHCC) clinics.
- Freestanding birth center staff.

ODM fee-for-service requires the NPI of the professionals referenced above to be on the Claim and will deny Claims that do not include the rendering NPI.

Home health and waiver Providers are not required to have an NPI on the Claim and will continue to submit Claims with the current process.

Ordering, Referring, and Prescribing (ORP) Providers NPI

As of July 1, 2021, Molina requires the billing of Ordering, Referring and Prescribing (ORP) Providers based upon the requirements developed by ODM in compliance with federal regulation 42 CFR 438.602 and 42. CFR 455.410. Claims billed with the attending field information will also be used to satisfy the ORP requirements.

Consistent with these rules, a valid National Provider Identifier (NPI) will be required on claims for select ORP Provider types which are eligible to order, refer or prescribe. For the most current listing of impacted Providers view the Provider Bulletin ORP NPI articles in the Provider Bulletins archived on the Molina Provider Website.

Required Elements

The following information must be included on every Claim:

- Member name, date of birth and Molina Member ID number
- Member's gender
- Member's address
- Date(s) of service
- Valid International Classification of Diseases diagnosis and procedure codes
- Valid revenue, Current Procedural Technology (CPT) or Healthcare Common Procedure Coding System (HCPCS) for services or items provided
- Valid diagnosis pointers
- Total billed charges
- Place and type of service code
- Days or units, as applicable (anesthesia Claims require minutes)
- Provider tax identification number (TIN)
- 10-digit National Provider Identifier (NPI)
- Rendering Provider name as applicable
- Billing/pay-to Provider name and billing address
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans
- E-signature
- Service facility location information
- Other insurance information, as applicable
- HIPAA-compliant CPT, HCPCS and modifier code sets
- Billed charges for each service line
- For prenatal or delivery services, the last menstrual period (LMP) date is required
- Global Delivery Claims need to file documentation of Postpartum visits

- Valid 11-digit National Drug Code (NDC) number – required to be billed for HCPCS codes in the J series; HCPCS codes in the Q or S series that represent drugs; CPT codes in the 90281-90399 series (immune globulins); and Enteral Nutritional B Code Products that price AWP (B4150-B4162)

Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the Claim.

Report all drugs billed to Molina that were acquired through the 340B drug pricing program spending with an SE modifier, so they can be properly excluded from federal drug rebates. As a reminder, Providers must be certified on the Provider Master File with a valid Medicaid ID and NPI.

D. EDI Claim Submission Issues

Providers who are experiencing EDI submission issues should work with their Clearinghouse to resolve this issue. If the Provider's Clearinghouse is unable to resolve, the Provider may call the Molina EDI customer service line at (866) 409-2935 or email us at EDI.Claims@MolinaHealthcare.com for additional support.

E. Paper Claim Submissions

Participating Providers should submit Claims electronically. If electronic Claim submission is not possible, please submit paper Claims to the following address:

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

Please keep the following in mind when submitting paper Claims:

- Paper Claims should be submitted on original red colored CMS-1500 Claim forms.
- Paper Claims must be printed, using black ink.

F. Corrected Claims

Corrected Claims are considered new Claims for processing purposes. Corrected Claims must be submitted electronically with the appropriate fields on the 837I or 837P completed. The Provider Portal includes functionality to submit corrected Institutional and Professional Claims. Corrected Claims must include the correct coding to denote if the Claim is a Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P and include the original Claim number.

G. Corrected Claim Process

Providers may correct any necessary field of the CMS-1500 and UB-04 forms. The descriptions of each field for a CMS-1500.

Corrected Claims may be submitted electronically via EDI and the Provider Portal.

All Corrected Claims:

- Must be free of handwritten or stamped verbiage (paper Claims).
- Must be submitted on a standard red and white UB-04 or CMS-1500 Claim form (paper Claims).
- Original Claim number must be inserted in field 64 of the UB-04 or field 22 of the CMS-1500 of the paper Claim, or the applicable 837 transaction loop for submitting corrected claims electronically.
- The appropriate frequency code/resubmission code must also be billed in field 4 of the UB-04 and 22 of the CMS-1500.

Note: The frequency/resubmission codes can be found in the NUCC (National Uniform Claim Committee) manual for CMS-1500 Claim forms or the UB Editor (Uniform Billing Editor) for UB-04 Claim forms.

Corrected Claims must be sent within 365 calendar days of the most recent adjudicated date of the Claim.

Claims submitted without the correct coding will be returned to the Provider for resubmission.

Corrected Claim submissions are not adjustments and should be directed through the original submission process marked as a corrected Claim, as outlined below, or it may result in the Claim being denied. As a reminder: Primary insurance Explanation of Benefits (EOB) and itemized statements are not accepted via Claim reconsideration. Please submit as corrected Claims.

Corrected Claims

Reminders for the Corrected Claims Process:

- Submit electronically or on the Provider Portal.
- Include all elements that need correction, and all originally submitted elements.
- Do not submit only codes edited by Molina.
- Do not submit via the Claim reconsideration process.
- Do not submit paper corrected Claims.
- Include the original Molina Claim ID number.

Corrected Claims must be received by Molina no later than the filing limitation stated in the Provider contract or within 365 days of the original remittance advice.

Directions on how to correct or void a Claim in the Provider Portal can be found in the Claim Features Training at MolinaHealthcare.com/OhioProviders under the "Manual" tab. You can also call Provider Services at (855) 322-4079 Monday through Friday from 8 a.m. to 6 p.m. for Molina Dual Options MyCare Ohio or 8 a.m. to 5 p.m. for all other lines of business.

1. Provider Portal Submission

- Go to provider.MolinaHealthcare.com
- Log in with your username and password
- Select "Create a professional Claim" from the left menu
- Select the radio button for the correct Claim option
- Enter the ID number of the Claim you want to correct
- Make corrections and add supporting documents or an explanation of benefits (EOB)
- Submit your Claim

2. Electronic Submission: EDI (Clearinghouse) Submission

837P

- In the 2300 Loop, the CLM segment (Claim information) CLM05-3 (Claim frequency type code) must indicate one of the following qualifier codes:
  - "1" – ORIGINAL (initial Claim)
  - "7" – REPLACEMENT (replacement of prior Claim)
  - "8" – VOID (void/cancel of prior Claim)
- The 2300 Loop, the REF *F8 segment (Claim information), must include the original reference number (Internal Control Number/Document Control Number ICN/DCN)

837I

- Bill type for UB Claims are billed in loop 2300/CLM05-1
  - In Bill Type for UB, the 1, 7 or 8 goes in the third digit for "frequency"
- In the 2300 Loop, the REF *F8 segment (Claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN)

Molina Healthcare of Ohio payer ID for electronic submission is 20149.

CMS-1500

Claims can be corrected using the Provider Portal.

Attachments

When submitting attachments through the Provider Portal:

- Supported file formats are PDF, TIFF, JPG, BMP and GIF.

- If a file exceeds 128 MB an alert will be sent, and the Claim will not process.
  - For files that exceed 128 MB contact your Provider Representative for submission alternatives.

H. Coordination of Benefits (COB) and Third Party Liability (TPL)

Medicaid Coordination of Benefits (COB)

See the Timely Claim Filing section for filing time frame requirements to Molina.

Medicaid is the payer of last resort. Commercial, private and governmental carriers must be billed prior to billing Molina or Medical Groups/IPAs. Provider shall make reasonable inquiry of Members to learn whether a Member has health insurance, benefits or Covered Services other than from Molina or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Molina of said entitlement. In the event coordination of benefits occurs, the Provider shall be compensated based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including explanation of benefits (EOBs) and other required documents, by utilizing the Provider Portal. Providers can also submit this information through EDI and paper submissions.

Primary insurance information can be populated on electronic Claims. Consistent with HIPAA 5010 billing guidelines, Providers are required to report the following COB information:

- COB carrier name
- Carrier ID
- Paid amounts
- Disallowed amount using respective CARCs/RARC
- Paid date

The 5010 Companion Guide is available at MolinaHealthcare.com/OhioProviders under the "EDI ERA/EFT" tab.

When submitting through the Molina Provider Portal, Providers will need to attach a copy of the primary carrier's EOB.

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

Molina follows the applicable regulatory guidance associated with COB. These include:

- OAC 3901-8-01 Coordination of Benefits
- OAC 5160-1-05 Medicaid Coordination of Benefits with the Medicare Program (Title XVIII)
- OAC 5160-1-05.1 Payment for Medicare Part C Cost Sharing
- OAC 5160-1-05.3 Payment for Medicare Part B Cost Sharing
- OAC 5160-1-08 Coordination of Benefits
- OAC 5160-2-25 Coordination of Benefits: Hospital Services
- OAC 5160-3-64.1 Nursing Facilities (NFs): Payment for Cost-Sharing Other Than Medicare Part A
- OAC 5160-26-09.1(C): Managed Health Care Programs: Third Party Recovery/Coordination of Benefits

Submitting Updated COB Information

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

If COB information has changed or termed, please submit the updated COB information directly to Molina by sending a secure email to MHOEnrollment@MolinaHealthcare.com for Medicaid Members, OHMMP_EnrollmentAccountingMHI@MolinaHealthcare.com for MyCare Ohio Dual Options Members or by sending a fax to (855) 714-2414 to the attention of the Enrollment Department.

Remember to include:

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

Health plans use the ODM Health Insurance Fact Request ODM 06614 available at medicaid.ohio.gov to verify COB information.

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

Provider Takes Reasonable Measures to Obtain Third Party Payment

Molina shall consider COB Claims for payment when a primary carrier has not processed the Claim in full when reasonable measures to obtain payment have been completed. In accordance with OAC 5160-26-09.1 Managed Health Care Programs: Third Party Liability and Recovery, reasonable measures are defined as follows:

- The Provider first submits a Claim to the primary payer for the rendered service(s) and does not receive a remittance advice or other communication within 90 days after the submission date. The Provider must provide documentation from the primary payer.
- The Provider has retained and/or submitted at least one of the following types of communication that indicates a valid reason, unrelated to Provider error, for non-payment of service(s):
  - Documentation from the primary payer.
  - Documentation from the primary payer's automated eligibility and Claim verification system.
  - Documentation from the primary payer's Member benefits reference guide.
  - Any other information and/or documentation from the primary payer illustrating there is no benefit coverage for the rendered service(s).
  - A screen print from the Provider's billing system.
- The Provider submitted a Claim to the primary payer and received a partial payment, along with a remittance advice, documenting the allocation of the charges.
  - Valid reasons for non-payment from a primary payer to the Provider for a third party benefit Claim include, but are not limited to, the following:
    - The Member does not have benefits through the primary payer for the date of service.
    - All the Provider's billed charges or the primary payer's approved rate was applied, in whole or in part, to the Member's benefit deductible amount, coinsurance and/or co-payment.
    - The Member has not met any required waiting periods, or residency requirements for their benefits, or was non-compliant with the primary payer's requirements in order to maintain coverage.
    - The Member is a dependent of the individual with benefits, but the benefits do not cover the individual's dependents.
    - The Member has reached the service(s) not covered under the Member's benefits.
    - The lifetime benefit for the medical service or benefits has been met.
    - The primary payer is disputing or contesting its liability to pay the Claim or cover the service.

Contractual timely filing provisions still apply.

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

Consistent with the Deficit Reduction Act of 2005 and the Ohio Administrative Code, Molina has an established process to identify third party liability through review and coordination of benefits (COB). This process may identify and coordinate benefits pre-claim or post-claim payment.

Definition: "Claim Reclamation" describes Molina's billing to a member's commercial third party coverage on behalf of a provider for reimbursement of the primary payment amount paid to the provider by Molina.

Effective for Molina claim payment dates on and after July 1, 2021, Molina offers providers additional time to bill the third party payor; shifting the timeframe from 120 days to 270 days of claim payment. The below details outline Molina's prior and updated third party liability COB process:

Pre-claim:

Provider receives Molina remittance advice denying the claim for other coverage/primary EOB as noted in the following grid.

Claim remit number	Claim remit message
377	EOB not received on Claim
216	No COB entered with a Secondary Enrollment

Post-claim:

- If Molina identifies commercial third party liability within 270 days from provider's payment date from Molina:
  - Molina will issue a letter to the provider stating the details of the third party payor identified by Molina as well as a request for refund of the impacted claims within 60 days.
  - Provider to perform COB and bill the third party payor identified.
  - Provider should refund Molina for the amount paid on the impacted claim(s) within 60 days.
  - If no refund is received from the provider within 60 days, Molina will recover the amount paid from future claim payments.
  - Upon receipt of third party payment, provider should submit the claim and third party remittance to Molina for COB, subject to timely filing requirements.
- If Molina identifies commercial third party liability more than 270 days from provider's payment date from Molina for *MyCare Ohio and Medicare lines of business*:
  - Molina will issue a letter to the provider stating the details of the third party payor identified by Molina as well as a request for refund of the impacted claims within 60 days.
  - Provider to perform COB and bill the third party payor identified.
  - Provider should refund Molina for the amount paid on the impacted claim(s) within 60 days.
  - If no refund is received from the provider within 60 days, Molina will recover the amount paid from future claim payments.

  - Upon receipt of third party payment, provider should submit the claim and third party remittance to Molina for COB, subject to timely filing requirements.
- If Molina identifies commercial third party liability more than 270 days from provider's payment date from Molina for *Medicaid and Marketplace lines of business*:
  - Molina will submit the provider's claim to the third party payor following the Claim Reclamation process.
  - OPT-OUT PROCESS: Providers may choose to opt-out of the Molina Claim Reclamation process. To do so, providers must submit a request to opt-out. The request will include the following elements:
    - Submitted on the provider's letterhead
    - List the specific tax identification number(s) to opt out
    - EMAIL TO: OHProviderServicesHospital@MolinaHealthcare.com

Risks of opt-out: For providers who opt-out of Claim Reclamation, Molina will recover claim payment via provider refund or recovery from future claim payments. In the event the third party payor denies the provider's claim due to timely filing or lack of medical necessity, Molina will also deny the claim as the secondary payer. Molina will also confirm the provider's claim meets Molina timely filing requirements for any additional payment as the secondary payer.

Coordination of Benefits for Global Obstetrical Claims

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

- Prenatal visits (Evaluation and Management [E&M] codes – append TH modifier, if appropriate).
- Delivery.
- Postpartum visits.

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

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

Medicaid Third Party Liability (TPL)

Molina is the payer of last resort and will make every effort to determine the appropriate third party payer for services rendered. Molina may deny Claims when third party has been

established and will process Claims for Covered Services when probable Third Party Liability (TPL) has not been established or third party benefits are not available to pay a Claim. Molina will attempt to recover any third party resources available to Members and shall maintain records pertaining to TPL collections on behalf of Members for audit and review.

MyCare Ohio Third Party Liability (TPL)

For Members enrolled in a Molina plan, Molina and/or contracted Medical Groups/IPAs are financially responsible for the care provided to these Members. Molina will pay Claims for covered services; however, if COB/TPL is determined Molina may request recovery post payment, if appropriate. Molina will attempt to recover any overpayments paid as the primary payer when another insurance is primary.

Ohio Medicaid, MMP Secondary and MMP Opt-Out Third Party Liability (TPL)

Molina is required to notify ODM and/or its designated agent within 14 calendar days of all requests for the release of financial and medical records to a Member or representative pursuant to the filing of a tort action. Notification must be made via the Notification of Third Party (tort) Request for Release Form (ODM 03245, rev. 7/2014).

Molina must submit a summary of financial information to ODM and/or its designated agent within 30 calendar days of receiving an original authorization to release financial Claim statement letter from ODM pursuant to a tort action. Molina must use the Notification of Third Party (Tort) Request for Release. Upon request, Molina must provide ODM and/or its designated agent with true copies of medical Claims.

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

Molina will pay Claims for Covered Services when third party benefits are not available. Molina does not recover TPL-related overpayments but will notify the ODM vendor to attempt to recover any third party resources available to Members and shall maintain records pertaining to TPL collections on behalf of Members for audit and review.

I. Medicaid Coverage for Molina Medicare Members

There are certain benefits that will not be covered by the Molina Medicare program but may be covered by **fee-for-service Medicaid**. In this case, the Provider should bill Medicaid with a copy of the Molina Medicare remittance advice and the associated State agency will process the Claim accordingly.

After exhausting all other primary coverage benefits, Providers may submit Claims to Molina Medicare. A copy of the remittance advice from the primary payer must accompany the Claim

or the Claim will be denied. If the primary insurance paid more than Molina's contracted allowable rate the Claim is considered paid in full and zero dollars will be applied to the Claim.

J. Federally Qualified Health Centers (FQHCs) / Rural Health Clinics (RHCs) Wrap-around Payments

The following are Molina's Medicaid Provider numbers for use when submitting documents for wrap-around payments.

Line of Business – Region:

- Medicaid – ABD
  - Molina Medicaid ID Number: 0077182
- Medicaid – CFC
  - Molina Medicaid ID Number: 0077186
- Molina Dual Options MyCare Ohio Medicare-Medicaid Plan
  - Molina Medicaid ID Number: 0082414

K. Enhanced Ambulatory Patient Grouping (EAPG) for Medicaid

The State of Ohio and all Managed Care Plans (MCP) have adopted version 3.14 of 3M's Enhanced Ambulatory Patient Grouping (EAPG) payment methodology for outpatient hospital Claims.

All hospitals that are subject to Diagnosis Related Group (DRG) prospective payment as described in rule OAC 5160-2-65 Inpatient Hospital Reimbursement and that provide covered outpatient hospital services to eligible Medicaid beneficiaries as defined in rule OAC 5160-2-02 General Provisions: Hospital Services are subject to the payment policies described in this rule. Hospital classifications referred to in this rule and the appendices are described in rule OAC 5160-2-05 Classification of Hospitals.

Hospitals exempt from prospective payment will continue to be paid reasonable costs as described in the Administrative Code OAC 5160-2-22 Non-DRG Prospective Payment for Hospital Services.

L. Hospital-Acquired Conditions and Present on Admission Program

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would modify reimbursement for fee-for-service beneficiaries when certain conditions occurred as a direct result of a hospital stay that could have been reasonably prevented using evidenced-based guidelines. CMS titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC and POA).

The following is a list of CMS Hospital Acquired Conditions. CMS reduced payment for hospitalizations complicated by these categories of conditions that were not Present on Admission (POA):

1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers
5. Falls and Trauma
    a. Fractures
    b. Dislocations
    c. Intracranial Injuries
    d. Crushing Injuries
    e. Burn
    f. Other Injuries
6. Manifestations of Poor Glycemic Control
    a. Hypoglycemic Coma
    b. Diabetic Ketoacidosis
    c. Non-Ketotic Hyperosmolar Coma
    d. Secondary Diabetes with Ketoacidosis
    e. Secondary Diabetes with Hyperosmolarity
7. Catheter-Associated Urinary Tract Infection (UTI)
8. Vascular Catheter-Associated Infection
9. Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
10. Surgical Site Infection Following Certain Orthopedic Procedures:
    a. Spine
    b. Neck
    c. Shoulder
    d. Elbow
11. Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
    a. Laparoscopic Gastric Restrictive Surgery
    b. Laparoscopic Gastric Bypass
    c. Gastroenterostomy
12. Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
13. Iatrogenic Pneumothorax with Venous Catheterization
14. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following Certain Orthopedic Procedures
    a. Total Knee Replacement
    b. Hip Replacement

What this means to Providers

- Acute Inpatient Prospective Payment System (IPPS) Hospital Claims will be returned with no payment if the POA indicator is coded incorrectly or missing.

- No additional payment will be made on IPPS hospital Claims for conditions that are acquired during the patient's hospitalization.

If you would like to find out more information regarding the Medicare HAC/POA program, including billing requirements, the following CMS site provides further information: cms.hhs.gov/HospitalAcqCond/.

M. Molina Coding Policies and Payment Policies

Frequently requested information on Molina's Coding Policies and Payment Policies is available on the MolinaHealthcare.com website under the Policies tab. Questions can be directed to your Provider Services Team.

N. Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate Claims. Molina requires coding of both diagnoses and procedures for all Claims. The required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM for diagnoses. For procedures, the Healthcare Common Procedure Coding System Level 1 (CPT codes), Level 2 and 3 Healthcare Common Procedure Coding System (HCPCS codes) are required for professional and outpatient Claims. Inpatient hospital Claims require ICD-10-PCS (International Classification of Diseases, 10th Revision, Procedure Coding System). Furthermore, Molina requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

Molina utilizes a Claims adjudication system that encompasses edits and audits that follow the state and federal requirements as well as administers payment rules based on generally accepted principles of correct coding. These payment rules include, but are not limited to, the following:

- Manuals and Relative Value Units (RVU) files published by the Centers for Medicare & Medicaid Services (CMS), including:
  - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUE).
    - In the event a state benefit limit is more stringent/restrictive than a federal MUE, Molina will apply the state benefit limit.
    - Furthermore, if a professional organization has a more stringent/restrictive standard than a federal MUE or state benefit limit, the professional organization standard may be used.
  - In the absence of state guidance, Medicare National Coverage Determinations (NCD).
  - In the absence of state guidance, Medicare Local Coverage Determinations (LCD).
  - CMS Physician Fee Schedule RVU indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).

- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific Claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than state and federal guidelines.
- Molina policies based on the appropriateness of health care and Medical Necessity.
- Payment policies published by Molina.

O. Telehealth Claims and Billing

Providers must follow CMS guidelines as well as the ODM telehealth billing guidelines.

All telehealth Claims for Molina Members must be submitted to Molina with correct codes and appropriate modifiers for the plan type and service.

Guidance for Medicaid as Primary Payer: The GT modifier, and any other appropriate modifiers, should be included on all telehealth claims and the POS should accurately reflect the physical location of the practitioner**.

*The only exception to this guidance is for Home Health Services, RN Assessment and RN Consultation. POS 02 should be used to indicate telehealth for the following codes: G0156, G0299, G0300, T1001, T1001 with U9 Modifier, G0151, G0152, G0153.

**Community behavioral health Providers should follow the guidance provided in the Ohio Department of Medicaid Behavioral Health Provider Manual.

Guidance for Medicare as Primary Payer: Use the telehealth POS Code 02, which certifies that the service meets the telehealth requirements. By coding and billing a POS 02 with a covered telehealth procedure code, the provider is certifying the member was present at an eligible originating site when the telehealth services were performed. Modifier GQ/GT/95 is required when applicable. GQ represents services provided not in real time such as remote patient monitoring or “store and forward” of information like photographs. GT represents services provided in real time (such as through video consultations). Modifier 95 is used for commercial insurance in place of GT for a set of specific E&M codes as Medicare limits originating site to rural areas. Place of service 02 (telehealth) indicates that telehealth was the place of service. Qualifying telehealth units of service for an originating site must be billed with Q3014 for reimbursement of facility fee.

P. National Correct Coding Initiative (NCCI)

CMS has directed all federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act. Molina uses NCCI standard payment methodologies.

NCCI Procedure to Procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by the same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes Medically Unlikely Edits (MUEs), which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same Provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

Q. General Coding Requirements

Correct coding is required to properly process Claims. Molina requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

CPT and HCPCS Codes

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the American Medical Association (AMA) CPT and HCPCS codebooks. In order to ensure proper and timely reimbursement, codes must be effective on the date of service (DOS) for which the procedure or service was rendered and not the date of submission.

Modifiers

Modifiers consist of two alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. **Modifiers may be appended only if the clinical circumstances justify the use of the modifier(s)**. For example, modifiers may be used to indicate whether a:

- Service or procedure has a professional component.
- Service or procedure has a technical component.
- Service or procedure was performed by more than one physician.
- Unilateral procedure was performed.
- Bilateral procedure was performed.
- Service or procedure was provided more than once.
- Only part of a service was performed.

For a complete listing of modifiers and their appropriate use, consult the AMA CPT and the HCPCS code books.

ICD-10-CM/PCS Codes

Molina utilizes International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) billing rules and will deny Claims that do not meet Molina's ICD-10 Claim Submission Guidelines. To ensure proper and timely reimbursement, codes must be effective on the dates of service (DOS) for which the procedure or service was rendered and not the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

Place of Service (POS) Codes

Place of Service Codes (POS) are two-digit codes placed on health care professional Claims (CMS-1500) to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry. The POS should be indicative of where that specific procedure/service was rendered. If billing multiple lines, each line should indicate the POS for the procedure/service on that line.

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

- 00: Unassigned
- 01: Pharmacy
- 02: Telehealth (Only for Medicare as Primary Payer; POS 02 will be denied for Medicaid as Primary Payer, unless stated otherwise in ODM's telehealth billing guidelines)
- 03: School (Only valid for Medicaid BH services)
- 04: Homeless Shelter
- 05: Indian Health Service – Free-standing facility
- 07: Tribal 638 – Free-standing facility
- 08: Tribal 638 – Provider-based facility
- 09: Unassigned
- 10: Unassigned
- 18: Unassigned
- 27-30: Unassigned
- 35-40: Unassigned
- 43-48: Unassigned
- 58-59: Unassigned
- 63-64: Unassigned
- 66-70: Unassigned
- 73-80: Unassigned
- 82-98: Unassigned

Type of Bill

Type of bill is a four-digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies

the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC) Official UB-04 Data Specifications Manual.

Revenue Codes

Revenue codes are four-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the NUBC's Official UB-04 Data Specifications Manual.

Diagnosis Related Group (DRG)

Facilities contracted to use DRG payment methodology submit Claims with DRG coding. Claims submitted for payment by DRG must contain the minimum requirements to ensure accurate Claim payment.

Molina processes DRG Claims through DRG software. If the submitted DRG and system-assigned DRG differ, the Molina-assigned DRG will take precedence. Providers may appeal with medical record documentation to support the ICD-10-CM principal and secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the Claim cannot be grouped due to insufficient information, it will be denied and returned for lack of sufficient information.

National Drug Code (NDC)

The 11-digit National Drug Code number (NDC) must be reported on all professional and outpatient Claims when submitted on the CMS-1500 Claim form, UB-04 or its electronic equivalent.

Providers will need to submit Claims with both HCPCS and NDC codes with the exact NDC that appears on the medication packaging in the 5-4-2 digit format (i.e., xxxxx-xxxx-xx) as well as the NDC units and descriptors. Claims submitted without the NDC number will be denied.

R. Coding Sources

Definitions

CPT – Current Procedural Terminology 4th Edition; an American Medical Association (AMA) maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. There are three types of CPT codes:

- Category I Code – Procedures/Services
- Category II Code – Performance Measurement
- Category III Code – Emerging Technology

HCPCS – Health Care Common Procedural Coding System; a CMS maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify procedure, supply and durable medical equipment codes furnished by physicians and other health care professionals.

ICD-10-CM – International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM diagnosis codes are maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

ICD-10-PCS - International Classification of Diseases, 10th revision, Procedure Coding System used to report procedures for inpatient hospital services.

S. Covered and Non-Covered Days

Value code 80 (Medicaid Covered Days) must be present on inpatient and long-term care claims or the claims will be denied. Institutional (UB) outpatient services are excluded from this requirement.

- Units billed with value code 80 are the number of covered full days and must correspond with units billed on the room and board claim line
- In the value code field, the number of covered days must be entered to the left of the dollars/cents delimiter
- Value Code 80 and corresponding units exclude non-covered days, leave of absence days or the day of discharge or death

Claims with non-covered days must bill value code 81 (Medicaid Non-Covered Days) to indicate the total number of full days that are not reimbursable.

- Units billed with value code 81 are the number of non-covered full days and must correspond with units billed on the room and board claim line
- In the value code field, the number of non-covered days must be entered to the left of the dollars/cents delimiter
- Charges related to the non-covered days would be reported under Total Charges and Non-Covered Charges on the room and board claim line
- The discharge date or day of death should not be included as a non-covered day in the value code or the room and board line
- Claims reporting non-covered days must report an occurrence code of 74 with the date span of the non-covered days

Note:

- If the covered and non-covered days' values are not reported on separate lines, the claim will be denied
- The total covered days and non-covered days billed must match at the line and header level

- This process must be followed by the provider for billing collapsed preventable readmissions

For more information please visit medicaid.ohio.gov and review the "Appendix G – Value Codes" in the ODM Hospital Billing Guidelines located under "Resources," then "Publications" and "ODM Guidance."

T. FQHC Transportation Reimbursement

Pursuant to OAC 5160-28-03.1 Cost-based Clinics: FQHC Services, Co-Payments, and Limitations, Molina will pay a per trip fee for transportation services provided by all Federally Qualified Health Centers (FQHC) that have a transportation contract with the ODM.

- Trip must be to or from an FQHC service site where a covered visit takes place on the same date of service.
- Molina will be paying $25.00 per trip or the lessor of billed charges, regardless of units billed.
- Claim must be billed using T2003.

U. Nursing Facility Guidelines

In order to ensure timely payment for skilled nursing and assisted living waiver Providers and reduce the manual burden associated with unnecessary Claim rejections and/or denials, the billing guidance available at MolinaHealthcare.com/OhioProviders under the "Manual" tab on the MyCare Ohio line of business should be utilized by all nursing facilities.

This information was obtained from current Medicare and Medicaid billing practices found in the National Uniform Billing Committee (NUBC) UB-04 Uniform Billing Manual and Transaction and Code Set Standards of Centers for Medicare and Medicaid Services (CMS).

Part B Therapies: Therapy Cap Authorization Requirement

In accordance with the Bipartisan Budget Act (BBA) of 2018, Medicare Claims are no longer subject to the therapy caps:

- One cap for occupational therapy services.
- One cap for physical therapy and speech-language pathology combined.

For Molina Medicare Plans, Claims for therapy services above a certain amount of incurred expenses, which is the same amount as the previous therapy caps, continue to require prior authorization

V. Patient Liability

Patient Liability (PL) is the monthly amount that a Member may be required to contribute to the cost of their care depending on the individual state income regulations for the following services:

- Nursing Facilities
- Hospice
- Assisted Living
- Certain Home and Community-Based Waiver Services
- Personal Care Aid
- Home Care Attendant
- Nursing Services
- Adult Day Services

This amount is calculated using the Member's income and subtracting reasonable allowances for personal needs and other living expenses. Nursing facilities and home health agencies are required to collect the entire PL due each month. Payments made to nursing facilities are reduced by the PL amount due for the months billed.

Additional information for PL is available in our Patient Liability Guide located on our website at MolinaHealthcare.com/OhioProviders under the "Manual" tab on the MyCare Ohio line of business, select "Quick Reference Guides & FAQs."

W. Claim Auditing

Molina shall use established industry Claim adjudication and/or clinical practices, State and federal guidelines and/or Molina's policies and data to determine the appropriateness of the billing, coding and payment.

Provider acknowledges Molina's right to conduct pre- and post-payment billing audits. The Provider shall cooperate with Molina's Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies and other related data as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon Molina's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

In reviewing medical records for a procedure, Molina may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims Molina paid in error. The estimated proportion, or error rate, may be projected across all Claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal Claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor assisted. Molina asks that you provide Molina, or Molina's designee, during normal business hours,

access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If Molina's Special Investigations Unit suspects that there is fraudulent or abusive activity, we may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

Effective Coding of Evaluation and Management Services

In an ongoing effort to ensure accurate Claims processing and payment, Molina is taking additional steps to verify the accuracy of payments made to professional Providers. Beginning on August 1, 2020, as part of our claims process, Molina will be reviewing select Claims for Evaluation and Management (E/M) services to better ensure that payments are aligned with national industry coding standards.

Providers should report E/M services in accordance with the American Medical Association's (AMA) CPT Manual and the Centers for Medicare and Medicaid Services' (CMS) guidelines for billing E/M service codes: Documentation Guidelines for Evaluation and Management. The level of service for E/M service codes is based primarily on the Member's medical history, examination and medical decision-making. Counseling, coordination of care, the nature of the presenting problem and face-to-face time are considered contributing factors.

Medical Necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be Medically Necessary or appropriate to bill a higher level of evaluation and management service when a lower level or service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.

CMS Regulations and Guidance 30.6.1/Selection of Level of Evaluation and Management Services, A – Use of CPT Code (cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r178cp.pdf)

If you disagree with Molina's findings after this review, you have the right to appeal the decision. Please follow the standard Claim Reconsideration process indicated in the Provider Manual.

X. Medicaid Timely Claim Processing

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina have agreed in writing, or an alternate schedule is required by ODM, Molina will process the Claim for service within 30 days after receipt of Clean Claims.

Y. MyCare Ohio Timely Claim Processing

A complete Claim is a Claim that has no defect, impropriety, lack of any required substantiating documentation as outlined in "Required Elements" earlier in this section, or particular circumstances that requiring special treatment that prevents timely payment from being made on the Claim.

Claim 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 have agreed in writing, or an alternate schedule is required by ODM, Molina will process the Claim for services as follows:

- 90% of all submitted "clean" claims are to be adjudicated within 30 calendar days of receipt.
- 99% of all submitted "clean" claims are to be adjudicated within 90 calendar days of receipt.

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

Z. Electronic Claim Payment

Participating Providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, provides searchable ERAs, and Providers receive payment and ERA access faster than the paper check and Remittance Advice (RA) processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at MolinaHealthcare.com/OhioProviders under the EDI ERA/EFT tab or by contacting our Provider Services Department.

ProviderNet

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

Registration is easy. Follow these simple steps:

1. Visit providernet.adminisource.com and select "Register"
2. Verify your information
   a. Select Molina from the payers list
   b. Enter your primary NPI, tax ID and a recent check number associated with the NPI/tax ID combination
3. Enter your user account information and use your email address as your user name
4. Verify your contact information, bank account information and payment address

   a. **Note:** Any changes to this address may interrupt the EFT process
5. Sign and return the automated clearinghouse (ACH) form with a **voided** check from your registered account immediately
6. Add any additional payment addresses, accounts and tax IDs once you have logged in

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

If you have any questions regarding the actual registration process, please contact ProviderNet customer service at (877) 389-1160 or email wco.provider.registration@changehealthcare.com.

AA. Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of Claim payment, Molina determines that it has made an overpayment to a Provider for services rendered to a Member, Molina will make a request for such overpayment.

Providers will receive an overpayment request letter if the overpayment is identified in accordance with state and CMS guidelines. Providers will be given the option to either:
1. Submit a refund to satisfy overpayment,
2. Submit request to offset from future claim payments, or
3. Dispute overpayment findings.

Instructions will be provided on the overpayment notice and overpayments will be adjusted and reflected in your remittance advice. The letter timeframes are Molina standards and may vary depending on applicable state guidelines and contractual terms.

Overpayments related to TPL/COB will contain primary insurer information necessary for rebilling including the policy number, effective date, term date, and subscriber information. For Members with Commercial COB, Molina will provide notice within 270 days from the Claim's paid date if the primary insurer is a Commercial plan. For Members with Medicare COB Molina will provide notice within 540 days from the Claim's paid date if the primary insurer is a Medicare plan. A Provider may resubmit the Claim with an attached primary EOB after submission to the primary payer for payment. Molina will adjudicate the claim and pay or deny the claim in accordance with Claim processing guidelines.

A Provider shall pay a Claim for an overpayment made by Molina which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider.

If a Provider does not repay or dispute the overpaid amount within the timeframe allowed, Molina may offset the overpayment amount(s) against future payments made to the Provider.

Payment of a Claim for overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to Molina, or the date that the Provider receives a payment from Molina that reduces or deducts the overpayment.

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

In the event the Provider incorrectly receives a check or finds an overpayment, please send the refund with a copy of the remittance advice and Claim information to:

Please direct payment and any correspondence to:

Molina Healthcare of Ohio
Dept. 781661 P.O. Box 78000
Detroit, MI 48278

If returning a Molina Healthcare check, please send to:

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

BB. Claim Reconsiderations (not related to an Authorization/Medical Necessity Review)

Submit Claim reconsiderations only when disputing a payment denial, payment amount or a code edit. As a reminder: Primary insurance Explanation of Benefits (EOB), corrected Claims, and itemized statements are not accepted via Claim reconsideration. Please refer to the Corrected Claims submission guidelines and the Reference Guide for Supporting Document for Claims posted on the Provider Website.

A Claim reconsideration must be submitted within 120 calendar days from the disputed Claim remit date.

Use the Provider Portal to submit the reconsideration online.

- You can access the Provider Portal at provider.MolinaHealthcare.com.
- You will need to log in with your User ID and Password.
- Open the Claims drop down menu from the home page.
- Search for the Claim you would like to have reconsidered by the Claim ID or patient information.
- Once the search function has identified the Claim, select the Claim ID number to populate the Claim details.
- At the bottom of the Claim details will be the “Appeal Claim” button.

- Once selected, the appeal form to be completed will appear with some information pre-populated and you will have the option of adding supporting documents as an attachment. Please include your fax number in order to receive a timely response.
- Attachments totaling up to 128 MB can be included with the reconsideration request.

For more details please find our Claim Features training on our website under the Manual Tab.

Alternatively, Providers may fax the form and supporting documents to the Provider Resolution Team at:

- Medicaid and MyCare Ohio, Dual Options Medicaid Plan at (800) 499-3406
- MyCare Ohio, Dual Options Medicare Medicaid Plan at (562) 499-0610

The Claim Reconsideration Request Form (CRRF) must be filled out entirely and include the following details, or it will not be processed, and the Provider will be notified:

- Molina-assigned Claim Number
- Line of Business
- Member Name
- Member ID Number
- Date of Service
- Provider ID/NPI
- Provider Phone and Fax
- Detailed Explanation of the Appeal
- Pricing sheet, if disputing payment amount
- Supporting documents

Find the form at: MolinaHealthcare.com/OhioProviders under “Forms.” (Paper submissions received by mail will not be processed and the Provider will be notified.)

Note: According to Ohio regulations, health care Providers are not permitted to balance bill Medicaid Members for services or supplies provided.

Please Note: Requests for adjustments of Claims paid by a delegated Medical Group/IPA must be submitted to the group responsible for payment of the original Claim.

The Provider will be notified of Molina’s decision in writing within state and contract requirements.

CC. Authorization Reconsiderations for Medical Necessity

For Medicaid services and MyCare Ohio inpatient, the Provider can request a reconsideration of a prior authorization denial.

A Medical Necessity Authorization Reconsideration can be submitted via Molina's Provider Portal (only if a Claim has been filed) or fax:

- Medicaid: within 30 calendar days of the date on the authorization denial/ non-approval notification.
- MyCare Ohio: within 30 calendar days of the date on the authorization denial/ non-approval notification or until the claim is processed.

The Authorization Reconsideration Form can be found at MolinaHealthcare.com/OhioProviders.

For additional information view the Authorization and Claim Reconsideration Guides available on our website, under the "Forms" tab on the Marketplace website, and under the "Manual" tab on all other lines of business. These guides are specific to each line of business. Please confirm the line of business the member is eligible under and reference the correct guide for the reconsideration process and appeal rights.

DD. Provider Claim Reconsiderations – Contracted Providers

Providers disputing a Claim previously adjudicated must request such action within 120 calendar days of Molina's original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.); all Claim disputes must be submitted on the Molina Claims Request for Reconsideration Form (CRRF) found on Provider Website and the Provider Portal. The form must be filled out completely in order to be processed.

Additionally, the item(s) being resubmitted should be clearly marked as a reconsideration and must include the following:

- Any documentation to support the adjustment and a copy of the Authorization form (if applicable) must accompany the reconsideration request.
- The Claim number clearly marked on all supporting documents.

Requests for Claims Disputes/Reconsiderations should be sent via the following methods:

- Provider Portal: provider.MolinaHealthcare.com
- Fax Dispute:
  - Medicaid and MyCare Ohio, Dual Options Medicaid Plan at (800) 499-3406
  - MyCare Ohio, Dual Options Medicare Medicaid Plan at (562) 499-0610
- Fax Authorization Reconsideration Pre-Claim Medicare: (877) 708-2116
- Fax Authorization Reconsideration Post-Claim:
  - Medicaid and MyCare Ohio, Dual Options Medicaid Plan at (800) 499-3406
  - MyCare Ohio, Dual Options Medicare Medicaid Plan at (562) 499-0610

Please Note: Requests for adjustments of Claims paid by a delegated Medical Group/IPA must be submitted to the group responsible for payment of the original Claim.

The Provider will be notified of Molina's decision in writing within 60 days of receipt of the Claims Dispute/Adjustment request.

EE. MyCare Ohio Provider Reconsideration of Delegated Claims – Contracted Provider

Providers requesting a reconsideration, correction or reprocessing of a Claim previously adjudicated by an entity that is delegated for Claims payment must submit their request to the delegated entity responsible for payment of the original Claim.

FF. Balance Billing

Per Federal Law, Members who are dually eligible for Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the State or another payer such as a Medicaid Managed Care Plan is responsible for paying such amounts. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

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

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. Balance billing a Molina Member for Covered Services is prohibited, other than for the Member's applicable copayment, coinsurance and deductible amounts.

Members who are dually eligible for Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the state or another payer such as a Medicaid Managed Care Plan is responsible for paying such amounts.

In accordance with OAC 5160-26-05 Managed Health Care Programs: Provider Panel and Subcontracting Requirements, a Provider may only bill a Molina Member when the Managed Care Plan (MCP) has denied prior authorization or referral for services and the following conditions are met:

- The Member was notified by the Provider of the financial liability in advance of service delivery.
- The notification by the Provider was in writing, specific to the service being rendered, and clearly states that the Member is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose.
- The notification is dated and signed by the member.

The agreement must be specific to the services being rendered and clearly state:

- The service is not covered by ODM or Molina.

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

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

GG. Fraud and Abuse

Failure to report instances of suspected Fraud and Abuse is a violation of the law and subject to the penalties provided by law. Please refer to the Compliance section of this Provider Manual for more information.

HH. Encounter Data

Each Provider, capitated Provider, or organization delegated for Claims processing is required to submit encounter data to Molina for all adjudicated Claims. The data is used for many purposes, such as regulatory reporting, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS® reporting.

Encounter data must be submitted weekly, in order to meet state and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X 12N 837I – Institutional, 837P – Professional and 837D – Dental. Data must be submitted with Claims-level detail for all non-institutional services provided.
For CMS, 80% of Claims must be submitted within 180 days from date of service. Additionally, 90% of medical and pharmacy Claims should be accepted by the state within 35 days of the end of the month in which the Claims were paid. For instance, 90% of all Claims paid in Feb. 2019

should be submitted to the state by April 4, 2019 (35 days from Feb. 28, 2019). State and CMS encounter submission threshold and quality measures depend on meeting these requirements.

Molina has a comprehensive automated and integrated encounter data system capable of supporting all 837 file formats and proprietary formats if needed.

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

Molina has created 837P, 837I, and 837D Companion Guides with the specific submission requirements available to Providers.

When Encounters are filed electronically Providers should receive two types of responses:
- First, Molina will provide a 999 acknowledgement of the transmission
- Second, Molina will provide a 277CA response file for each transaction

VI. Medicaid: Health Care Services

A. Introduction

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

B. Utilization Management (UM)

Molina ensures the service delivered is medically necessary and demonstrates an appropriate use of resources based on the level of care needed for a Member. This program promotes the provision of quality, cost-effective, and medically appropriate services that are offered across a continuum of care as well as integrating a range of services appropriate to meet individual needs. Molina maintains flexibility to adapt to changes in the Member's condition and is designed to influence Member's care by:
- Managing available benefits effectively and efficiently while ensuring quality care.
- Evaluating the medical necessity and efficiency of health care services across the continuum of care.

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

Key Functions of the UM Program

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

Eligibility and Oversight	Resource Management	Quality Management
Eligibility verification	Prior Authorization and referral management	Satisfaction evaluation of the UM program using Member and Provider input
Benefit administration and interpretation	Pre-admission, Admission and Inpatient Review	Utilization data analysis
Verification that authorized care correlates to Member's medical necessity need(s) and benefit plan	Referrals for Discharge Planning and Care Transitions	Monitor for possible over- or under-utilization of clinical resources
Verifying of current Physician/hospital contract status	Staff education on consistent application of UM functions	Quality oversight
		Monitor for adherence to CMS, NCQA, state and health plan UM standards

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

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

UM Decisions

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

- Determination to authorize, provide or pay for services (favorable determination);
- Determination to deny, modify, or payment of request (adverse determination);
- Discontinuation of a payment for a service;
- Payment for temporarily out-of-the-area renal dialysis services; and,
- Payment for Emergency Services, post stabilization care or urgently needed services.

Molina follows a hierarchy of Medical Necessity decision making with federal and state regulations taking precedence. Molina covers all services and items required by state and federal regulations.

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

Requests for authorization not meeting criteria are reviewed by a designated Molina Medical Director or other appropriate clinical professional. Only a licensed physician or pharmacist, doctoral level clinical psychologist or certified addiction medicine specialist as appropriate may determine to delay, modify or deny payment of services to a Member.

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

Providers can contact Molina's Healthcare Services Department at (855) 322-4079 to obtain Molina's UM Criteria, or by noting the process in the MCG Cite for Care section directly below.

1. **Initial Organization Determinations/Pre-Service Authorization Requests –** 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. Molina and any delegated Medical Group/IPA or other delegated entity is responsible to appropriately log and respond to requests for expedited initial organization determinations.
    - Expedited Initial requests must be made as soon as medically necessary, within 48 hours (including weekends and holidays) following receipt of the validated request.
    - Standard requests must be made as soon as medically indicated, within a maximum of 10 calendar days after receipt of the request.

Delegated Medical Groups/IPAs or other delegated entities are responsible for submitting a monthly log of all Expedited Initial Determinations to Molina's Delegation Oversight Department that lists pertinent information about the expedited determination including Member demographics, data and time of receipt and resolution of the issue, nature of the problem and other information deemed necessary by Molina or the Medical Group/IPA or other delegated entities.

2. **Written Notification of Denial –** The Member must be provided with written notice of the determination, if the decision is to deny, in whole or in part, the requested service or payment. If the Member has an authorized representative, the representative must be sent a copy of the denial notice. The appropriate written notice, that has CMS approval, must be issued within established regulatory and certification timelines. The adverse organization determination notice shall be written in a manner that is understandable to the Member and shall provide the following:
   - The specific reason for the denial, including the precise criteria used to make the decision that takes into account the Member's presenting medical condition, disabilities and language requirements, if any.
   - Information regarding the Member's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the Member's behalf.
   - Include a description of both the standard and expedited reconsideration process, timeframes and conditions for obtaining an expedited reconsideration, and the other elements of the appeals process.
   - Payment denials shall include a description of the standard reconsideration process, timeframes and other elements of the appeal process.
   - A statement disclosing the Member's right to submit additional evidence in writing or in person.

   Failure to provide the Member with timely notice of an organization determination constitutes an adverse organization determination which may be appealed.

MCG Cite for Care Guideline Transparency

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

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

MCG Cite for Care 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 Care Guideline Transparency, visit MCG's website or call (888) 464-4746.

C. Delegation to Children's Hospital Organization

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

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

D. Medical Necessity

"Medically Necessary" or "Medical Necessity" means health care services that a physician, exercising prudent clinical judgement, would provide to a patient.

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

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

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

The fact that a Provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services medically necessary, a Medical Necessity or a Covered Service/Benefit.

Medical Necessity Review

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

Levels of Administrative and Clinical Review

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

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

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

Clinical Information

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

E. Prior Authorization (PA)

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

Providers are encouraged to use the Molina Prior Authorization Form provided on the Molina website. 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 (include treatment, diagnostic tests, examination data).
  - Requested length of stay (for inpatient requests).
  - Rationale for expedited processing.

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by federal and state law) are excluded from the prior authorization requirements. Obtaining authorization does not guarantee payment. Molina retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care. Molina does not retroactively authorize services that require PA; with the exception of extenuating circumstances. See the Extenuating Circumstances section below for additional information.

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

Providers who request prior authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina has a full-time Medical Director available to discuss Medical Necessity decisions with the requesting Provider at (855) 322-4079.

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

Note: If a request is denied for Inpatient Medicaid Members, the Member will not receive a letter explaining the reason for the denial.

Molina Peer-to-Peer Review Process

Upon receipt of an adverse determination, the Provider (peer) may request a peer-to-peer discussion within five calendar days of the decision for prior authorization requests.

A "peer" is considered a physician, physician assistant, nurse practitioner, or PhD psychologist who is directly providing care to the Member or a Medical Director on site at the facility. Calls from EHR and other similar contracted external parties, administrators, or facility UM staff are not peers and calls will not be returned.

To make the Peer-to-Peer request:

- Call Molina Healthcare Utilization Management at (855) 322-4079 from 8:30 a.m. to 5 p.m., Monday to Friday.
- Include two possible dates and times a licensed professional is available to conduct the review with a Molina medical director.

If the Peer-to-Peer does not change the outcome of a determination, or is not requested within five calendar days, Providers may request an authorization reconsideration within 30 calendar days of the date on the authorization denial notification. The authorization reconsideration must include new/additional clinical information to be considered. Once a determination has been rendered for the authorization reconsideration, no further authorization reconsiderations are available.

Also refer to the Provider Reference Guide detailing Molina's authorization and Claims reconsideration processes.

For Medicaid services the Provider can request a reconsideration of a prior authorization denial by faxing the request with supporting documentation within 30 calendar days from the date of the denial notification. Submit an Authorization Reconsideration Form via fax to (866) 449-6843. The form is posted online at MolinaHealthcare.com/OhioProviders under the "Forms" tab.

ProgenyHealth Peer-to-Peer Process: Providers who wish to conduct a Peer-to-Peer review will contact ProgenyHealth directly at (888) 832-2006.

ProgenyHealth Authorization Reconsideration: The 30-day authorization reconsideration process has been modified to exclude NICU authorizations based on our partnership with ProgenyHealth.

New Century Health Peer-to-Peer Process: Peer-to-Peers will be conducted by New Century Health via physician discussions with expanded collaboration to better discuss treatment plans.

New Century Health Authorization Reconsideration and Retro-Authorization Reviews: All retro-authorization and Extenuating Circumstances reviews should be sent to Molina following the process you use today. Effective April 1, 2022, the 30-day authorization reconsideration process was modified to exclude cardiology professional services listed below based on our partnership with New Century Health. Providers are strongly encouraged to take advantage of New Century Health's streamlined Peer-to-Peer process to hold timely conversations related to requested services.

This PA requirement applies to Medicaid and Marketplace (Exchange) members ages 18 and older for the following professional services:

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

Extenuating Circumstances—below is the list of Extenuating Circumstances that apply to both inpatient and outpatient authorization requirements. Within 120 days of the Claim denial, the Provider may file for an authorization reconsideration for the extenuating circumstances listed below; even if the authorization was not requested in advance of the service(s) being provided. The specific circumstance the Provider feels was applicable to the request should be noted on the reconsideration form, documentation to support the extenuating circumstance, as well as the applicable clinical information should be included with the request. In accordance with Molina policy, please remember to always verify enrollment using the Ohio Medicaid Program's Eligibility System (MITS):

- A newborn remains an inpatient longer than the mother and needs a separate authorization.
- Member was brought into facility unconscious and/or unable to provide insurance carrier information (Requires Provider to submit copy of registration face sheet and full description of why the documentation could not be obtained from the Member. In addition, Molina will review Claims/authorizations history for the past 6 months for validation purposes).
- Retro-enrollment/retro coordination of benefits (COB) change makes Molina Healthcare the primary carrier.
- Transition of Care/Continuity of Care.
- Abortion/Sterilization/Hysterectomy (operative reports are required).
- The service is not an included benefit in the primary insurance coverage (example: no maternity care benefits).

- A baby is born to a Member with other third party primary coverage and the baby is not covered under such coverage.
- Add-on codes, or changes in coding during the procedure (operative reports are required as applicable).
- Other circumstances as determined by Molina.

Requesting Prior Authorization

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

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

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

Provider Portal: Participating Providers are required to use the Provider Portal for prior authorization submission whenever possible. Instructions for how to submit a prior authorization request are available on the Provider Portal. The benefits of submitting your prior authorization request through the Provider Portal are:

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

Fax: View the Prior Authorization Request Form for a list of fax numbers by line of business and service type.

Mail: Prior authorization requests and supporting documentation can be submitted via U.S. mail at the following address:

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

Prior Authorization Guidelines and Request Form

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

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

- Clinical information sufficient to document the Medical Necessity of the requested service.
- Provider demographic information (referring Provider and referred to Provider/facility).
- Requested service/procedure, including all appropriate CPT, HCPCS, and ICD-10 codes.
- Location where service will be performed.
- Member diagnosis (CMS-approved diagnostic and procedure code and descriptions).
- Pertinent medical history (include treatment, diagnostic tests, examination data).
- Requested length of stay (for inpatient requests).
- Indicate if request is for Expedited/Urgent or Elective/Routine.

For more information visit the Molina website at MolinaHealthcare.com/OhioProviders and under the "Forms" tab review the PA Request Form and Instructions, and a codified list of all services that require a PA.

ProgenyHealth

Molina has partnered with ProgenyHealth for Neonatal Intensive Care Unit (NICU) Care Management. Providers are required to notify ProgenyHealth directly of admissions of infants to a NICU or special care nursery. The clinical staff at ProgenyHealth will contact the Provider's designated staff to perform UM and discharge planning throughout the inpatient stay.

The processes for Initial Reviews and Extenuating Circumstances Pre-Claim within 120 days of discharge are noted below:

- Providers submitting admission authorization requests via fax will use a new ProgenyHealth fax number at (866) 519-1259.
- Providers who wish to conduct a Peer-to-Peer review will contact ProgenyHealth directly at (888) 832-2006.
- The 30-day authorization reconsideration process has been modified to exclude NICU authorizations based on our partnership with ProgenyHealth.

New Century Health

As of April 1, 2022, Molina began collaborating with New Century Health to conduct Medical Necessity review on certain Prior Authorizations (PA). Medicaid and Marketplace participating providers are to submit PA requests for cardiovascular professional services' review and decisions for Molina members ages 18 and over to New Century Health for the following professional services:

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

- Thoracic Surgery
- Cardiac Surgery
- Electrophysiology

New Century Health will process cardiology PA requests for Providers who are in-network with Molina for the Medicaid or Marketplace lines of business. Out-of-network Providers should continue to send cardiology PA requests directly to Molina as they do today. Providers should continue to send any Medicare/MyCare Ohio Medicare PA requests for the above-referenced services directly to Molina as they do today. Behavioral Health Providers are also outside the scope of this new process.

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

- For Providers' convenience, logging into the New Century Health Provider Web Portal is the preferred submission method: my.newcenturyhealth.com
  - New Century Health's Provider Web Portal functionality offers instant approvals for PA requests
- Calling (888) 999-7713, Cardiology – Option 3
- Fax intake: (877) 622-6879

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

Further clarifications are noted below regarding New Century Health/Molina partnership:

- For inpatient service requests, the inpatient status will be approved simultaneously with the approval of the cardiovascular professional service(s) being reviewed. The inpatient admission length of stay will be determined by Inpatient Utilization Management (Concurrent Review) at the time of any needed hospitalization. Providers are to follow Molina's inpatient notification process as you do today, and the continued stay will be reviewed for medical necessity and decisioned at that time. If other services are being performed during the inpatient stay that are unrelated to the cardiac procedures, a separate authorization will need to be completed through Molina's standard prior authorization process for medical necessity determination.
- Please consult the posted PA code list for further guidance on where to submit cardiovascular professional services PA requests. PA requests for members under 18 years of age are to be routed to Molina, and applicable codes are noted as such in the PA code list. PA requests for members 18 years and older from participating providers are to be directed to New Century Health for the Medicaid and Marketplace lines of business. Non-

participating provider and/or Medicare/MMP Medicare line of business PA requests should be submitted to Molina for any codes requiring PA; regardless of the age of the member.

Experimental and Investigational Services are not Covered

Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation or treatment of a disease, injury, illness or other health condition which we determine in our sole discretion to be Experimental/Investigational is not covered.

We will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply to be Experimental/Investigational if we determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency; and such final approval has not been granted,
- Has been determined by the FDA to be contraindicated for the specific use; or,
- Is provided as part of a clinical research protocol or clinical trial, or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or,
- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; and/or,
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as Experimental/Investigational, or otherwise indicate that the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation.

Any service not deemed Experimental/Investigational based on the criteria above may still be deemed Experimental/Investigational by Molina. In determining whether a Service is Experimental/Investigational, we will consider the information described below and assess whether:

- The scientific evidence is conclusory concerning the effect of the service or drug on health outcomes,
- The evidence demonstrates the service or drug improves net health outcomes of the total population for whom the service or drug might be proposed by producing beneficial effects that outweigh any harmful effects,
- The evidence demonstrates the service or drug has been shown to be as beneficial for the total population for whom the service or drug might be proposed as any established alternatives; and,

- The evidence demonstrates the service or drug has been shown to improve the net health outcomes of the total population for whom the service or drug might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by Molina to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is Experimental/Investigational under the above criteria may include one or more items from the following list which is not all inclusive:

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or,
- Evaluations of national medical associations, consensus panels and other technology evaluation bodies; or,
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or,
- Documents of an IRB or other similar body performing substantially the same function; and/or,
- Whether there is FDA approval for the use for which benefits are sought; or
- Consent document(s) and/or the written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or
- Medical records; or,
- The opinions of consulting Providers and other experts in the field.

Molina has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is Experimental/Investigational

Clinical Trials: For information on clinical trials, go to cms.hhs.gov or call (800) MEDICARE.

Information Only: On September 19, 2000, the Health Care Financing Administration (HCFA) approved a National Coverage Policy that permits all Medicare Beneficiaries to participate in qualified clinical trials. For the initial implementation, Medicare will pay Providers and hospitals directly on a fee for service basis for covered clinical trial services for Members of Molina's Medicare plans and other Medicare HMO plans. The Provider and/or hospital conducting the clinical trial will submit all claims for clinical trial services directly to Medicare, not to the Medicare plan. This means the Member will be responsible for all Medicare fee for service deductibles and copayments for any services received as a participant in a clinical trial.

F. Open Communication about Treatment

Molina prohibits contracted Providers from limiting Provider or Member communication regarding a Member's health care. Providers may freely communicate with, and act as an

advocate for their patients. Molina requires provisions within Provider contracts that prohibit solicitation of Members for alternative coverage arrangements for the primary purpose of securing financial gain. No communication regarding treatment options may be represented or construed to expand or revise the scope of benefits under a health plan or insurance contract.

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

G. Delegated Utilization Management Functions

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

H. Communication and Availability to Members and Providers

During business hours HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff by calling (855) 322-4079 during normal business hours, Monday through Friday (except for holidays) from 8 a.m. to 6 p.m. for Molina Dual Options MyCare Ohio or 8 a.m. to 5 p.m. all other lines of business. All staff Members identify themselves by providing their first name, job title and organization.

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

After business hours, Providers can also utilize fax and the Provider Portal for UM access.

Molina's Nurse Advice Line is available to Members and Providers twenty-four (24) hours a day, 7 days a week, 365 days a year at (888) 275-8750. Molina's Nurse Advice Line handles urgent and emergent after-hours UM calls. Primary Care Physicians (PCPs) are notified via fax of all Nurse Advice Line encounters.

I. Emergency Services

Emergency Services means: covered inpatient services, outpatient services, or medical transportation services that are provided by a qualified provider and are needed to evaluate, treat, or stabilize an emergency medical condition. As used in this section, providers of emergency services also include physicians or other health care professionals or health care facilities not under employment or under contractual arrangement with an MCP.

Emergency Medical Condition or Emergency means: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant Member, the health of the Member or their unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

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

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

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

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

Members over-utilizing the emergency department will be contacted by Molina Care Managers to provide assistance whenever possible and determine the reason for using Emergency Services.

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

J. Inpatient Management

Elective Inpatient Admissions

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

Emergent Inpatient Admissions

Molina requires notification of all emergent inpatient admissions within 48 hours of admission or by following business day. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. Molina requires that notification includes Member demographic information, facility information, date of admission and clinical information sufficient to document the Medical Necessity of the admission. Emergent inpatient admission services performed without meeting admission notification Medical Necessity requirements or failure to include all of the needed clinical documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient stay; except in the event of Extenuating Circumstances. See the Extenuating Circumstances section earlier in this section for additional information.

Inpatient at Time of Termination of Coverage

If a Member's coverage with Molina terminates during a hospital stay, all services received after their termination of eligibility are not covered services. For additional information view OAC 5160-26-02 Managed health care program: eligibility and enrollment and OAC 5160-26-02.1 Managed health care programs: termination of enrollment.

Observation Policy

Molina has an inpatient utilization review policy. The goal is to ensure Members receive Medically Necessary services in the appropriate and most efficient and cost-effective setting. All inpatient admissions require PA. Similar to OAC 5160-26-03 Managed Health Care Programs: Covered Services, Molina will review and evaluate covered medical services to ensure procedures are Medically Necessary and provided in the most appropriate setting.

Molina evaluates inpatient behavioral health stays for observation level of care. All patient stays require either notification or PA depending on the type of service.

If inpatient admission clinical criteria are not met and observation clinical criteria are met, Molina will authorize an observation stay. For stays of two days or less, when clinical criteria are met for inpatient and observation, Molina will review and consider these for observation level of care. If you disagree with the decision and believe inpatient admission is necessary, a Molina medical director will review the case and make a determination.

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

Some exceptions to this policy include:

- Member leaves against medical advice (AMA).
- Member transferred to acute care facility.
- Member admitted for dialysis and/or end stage renal disease.

Prospective/Pre-Service Review

Pre-service review defines the process, qualified personnel and timeframes for accepting, evaluating and replying to prior authorization requests. Pre-service review is required for all non-emergent inpatient admissions, outpatient surgery and identified procedures, Home Health, some durable medical equipment (DME) and Out-of-Area/Out-of-Network Professional Services. The pre-service review process assures the following:

- Member eligibility.
- Member covered benefits.
- The service is not experimental or investigational in nature.
- The service meets Medical Necessity criteria (according to accepted, nationally-recognized resources).
- All Covered Services, (e.g., test, procedure) are within the Provider's scope of practice.
- The requested Provider can provide the service in a timely manner.
- The receiving specialist(s) and/or hospital is/are provided the required medical information to evaluate a Member's condition.
- The requested Covered Service is directed to the most appropriate contracted specialist, facility or vendor.
- The service is provided at the appropriate level of care in the appropriate facility; e.g., outpatient versus inpatient or at appropriate level of inpatient care.
- Continuity and coordination of care is maintained.
- The PCP is kept apprised of service requests and of the service provided to the Member by other Providers.

Inpatient/Concurrent Review

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

Failure to provide timely clinical information updates may result in denial of authorization for the remainder of the inpatient admission dependent on the Provider contract terms and agreements.

Molina will authorize hospital care as an inpatient when the clinical record supports the Medical Necessity for the need for continued hospital stay. It is the expectation that observation has been tried in those patients that require a period of treatment or assessment, pending a decision regarding the need for additional care, and the observation level of care has failed. Upon discharge the Provider must provide Molina with a copy of the Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

Inpatient Status Determinations

Molina's UM staff determine if the collected medical records and clinical information for requested services are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member" by meeting all coverage, coding and Medical Necessity requirements. To determine Medical Necessity, the criteria outlined under Medical Necessity Review" will be used. In addition to collected clinical documentation, Molina will use all information relevant to a Member's care in making coverage decisions.

Discharge Planning

The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission. UM staff work closely with the hospital discharge planners to determine the most appropriate discharge setting for Molina Members. The clinical staff review Medical Necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Readmissions

Readmission review is an important part of Molina's Quality Improvement Program to ensure that Molina Members are receiving hospital care that is compliant with nationally recognized guidelines as well as federal and state regulations.

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

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

When a subsequent admission to the same facility occurs within 2-30 days of discharge, and it is determined that the readmission is related to the first admission (readmission) and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions. For additional information see the "Readmission Payment Policy" on the Provider Website, under the "Policies" tab.

Post-Service Review

Failure to obtain authorization when required will result in denial of payment for those services. The only possible exception for payment as a result of post-service review is if information is received indicating the Provider did not know nor reasonably could have known that patient was a Molina Member or if there was a Molina error, a Medical Necessity review will be

performed. Decisions, in this circumstance, will be based on medical need, appropriateness of care guidelines defined by UM policies and criteria, CMS Medical Coverage Guidelines, Local and National Coverage Determinations, CMS Policy Manuals, regulation and guidance and evidence-based criteria sets.

Specific federal or state requirements or Provider contracts that prohibit administrative denials supersede this policy.

K. Affirmative Statement about Incentives

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

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

L. Out-of-Network Providers and Services

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

Avoiding Conflict of Interest

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

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

M. Coordination of Care and Services

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

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 practices 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.

Providers must offer the opportunity to provide assistance to identified Members through:

- Notification of community resources, local or state funded agencies.
- Education about alternative care.
- How to obtain care as appropriate.

N. Continuity of Care and Transition of Members

It is Molina's policy to provide Members with advance notice when a Provider they are seeing will no longer be in network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the Provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out-of-network Provider for a given period of time, and provide continued services to Members undergoing a course of treatment by a Provider that has terminated their contractual agreement if the following conditions exist at the time of termination:

- Acute condition or serious chronic condition – Following termination, the terminated Provider will continue to provide Covered Services to the Member up to 90 days or longer if necessary, for a safe transfer to another Provider as determined by Molina or its delegated Medical Group/IPA.
- High risk of second or third trimester pregnancy – The terminated Provider will continue to provide services following termination until postpartum services related to delivery are completed or longer if necessary, for a safe transfer.

For additional information regarding continuity of care and transition of Members, please contact Molina at (855) 322-4079.

O. Continuity and Coordination of Provider Communication

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

Transition of Care (TOC) Period

The Utilization Management and Care Management staffs facilitate the transition of care (TOC) for Members whose benefits have come to end. Alternatives to coverage are explored with the Member, the PCP, community resources and any new coverage to ensure continuity of care.

A complete list of the TOC requirements for Medicaid and MyCare Ohio lines of business can be found in Appendix B of this manual.

P. Reporting of Suspected Abuse and/or Neglect

A vulnerable adult is a person who is receiving or may be in need of receiving community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of themselves, or unable to protect themselves against significant harm or exploitation. When working with children one may encounter situations suggesting abuse, neglect and/or unsafe living environments.

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

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

Suspected abuse and/or neglect should be reported as follows:

Child Abuse:

The Ohio Department of Job and Family Services has launched 855-O-H-Child (855-642-4453), an automated telephone directory that will link callers directly to a child welfare or law enforcement office in their county.

Adult Abuse:

Adult protective services for adults age 60 and older can be reached at the Ohio Department of Job and Family Services at 855-OHIO-APS (855-644-6277).

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

Molina will follow up with Members who 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.

PCP Responsibilities in Care Management Referrals

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

Care Manager Responsibilities

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

- Assesses the Member to determine if the Members' 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 in order to determine an appropriate time for the Member's graduation from the ICM program.

Q. Health Management

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

Level 1 Health Management

Molina offers programs to help our Members and their families manage various health conditions. The programs include telephonic outreach from our clinical staff and health educators that includes condition specific triage assessment, care plan development and access to tailored educational materials. Members are identified via Health Risk assessments and Identification and Stratification. A Provider can also directly refer Members who may benefit from these program offerings at (855) 322-4079. Members can request to be enrolled or dis-enrolled in these programs at any time. Our programs include:

- Asthma management
- Diabetes management
- High blood pressure management
- Heart Failure
- Chronic Obstructive Pulmonary Disease (COPD) management
- Depression management
- Obesity
- Weight Management
- Smoking Cessation
- Organ Transplant
- Serious and Persistent Mental Illness (SPMI) and Substance Use Disorder
- Maternity Screening and High-Risk Obstetrics

For more information about these programs, please call (866) 472-9483 (TTY/TDD at 711 Relay).

R. Maternity Screening and High-Risk Obstetrics

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

S. Member Newsletters

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

T. Member Health Education Materials

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

U. Diabetes Self-Management Education (DSME)

Diabetes Self-Management Education (DSME) is a covered benefit for Members with diabetes. Members have access to training provided by educators in an American Diabetes Association (ADA)-recognized and/or Association of Diabetes Care and Education Specialists (ADCES)-accredited program.
The core content includes these self-care behaviors to help Members stay on track between office visits:

- Diabetes pathophysiology and treatment options
- Healthy eating
- Physical activity
- Medication usage
- Monitoring and using patient health data
- Preventing, detecting, and treating acute and chronic complications
- Healthy coping with psychosocial issues and concerns
- Problem solving

Depending on the DSME Provider in the Molina network, classes can be for an individual or a group.

V. Program Eligibility Criteria and Referral Source

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

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

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

W. Provider Participation

Contracted Providers are notified as appropriate when the Member is enrolled in a Health Management Program. Provider resources and services may include:

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

Additional information on Health Management Programs is available from your local Molina Healthcare Services Department toll free at (855) 322-4079.

Emergency Services and Post-Stabilization Services

Emergency Services means covered inpatient and outpatient services furnished by a Provider who is qualified to furnish these services and such services are needed to evaluate or stabilize an emergency medical condition.

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

Molina accomplishes this service by providing a 24 hour Nurse Triage option on the main telephone line for post business hours. In addition, the 911 information is given to all Members at the onset of any call to the plan.

For Members within our service area: Molina contracts with vendors that provide 24 hour Emergency Services for ambulance and hospitals.

Molina and its contracted Providers must provide emergency services and post-emergency stabilization and maintenance services to treat any Member with an Emergency Medical Condition in compliance with Federal Law. An Emergency Medical Condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Member including the health of a pregnant Member and/or their unborn child in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any body part.
- Serious disfigurement.

Molina covers maintenance care and post-stabilization services which are medically necessary, non-emergency services. Molina or its delegated entity arranges for post-stabilization services to ensure that the patient remains stabilized from the time the treating hospital requests authorization until the time the patient is discharged or a contracting medical Provider agrees to other arrangements.

Pre-approval of emergency services is not required. Molina requires the hospital emergency room to contact the Member's primary care Provider upon the Member's arrival at the emergency room. After stabilization of the Member, Molina requires pre-approval of further post-stabilization services by a participating Provider or other Molina representative. Failure to review and render a decision on the post-stabilization pre-service request within one hour of receipt of the call shall be deemed an authorization of the request.

Molina or its delegated entity is financially responsible for these services until Molina or its delegated entity becomes involved with managing or directing the Member's care.

Molina and its delegated entity provide urgently needed services for Members temporarily outside of the service area but within the United States or who have moved to another service area but are still enrolled with. Urgent Services are covered services that are medically necessary and are needed urgently, typically the same day or within two days of onset of symptoms, as judged by a prudent layperson.

Primary Care Providers

Molina provides a panel of PCPs to care for its Members. Providers in the specialties of Family Medicine, Internal Medicine and Obstetrics and Gynecology are eligible to serve as PCPs. Members may choose a PCP or have one selected for them by Molina. Molina's Medicare Members are required to see a PCP who is part of the Molina MyCare Ohio Medicare Network.

Molina's Members may select or change their PCP by contacting Molina's Member & Provider Contact Center.

Out-of-Network Specialty Providers

Molina maintains a network of specialty Providers to care for its Members. Members are allowed to directly access OB/GYN health specialists for routine and preventive health without a referral for services.

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

X. Care Management (CM)

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

The Molina Care Managers may be licensed professionals and are educated, trained and experienced in Molina's ICM program. The ICM program is based on a Member advocacy philosophy, designed and administered to assure the Member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes. The ICM program is individualized to accommodate a Member's needs with collaboration and input from the Member's PCP. The Molina Care Manager will assess the Member upon engagement after identification for ICM enrollment, assist with arrangement of individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services and preventive services. The Molina Care Manager is responsible for assessing the Member's appropriateness for the ICM program and for notifying the PCP of ICM program enrollment, as well as facilitating and assisting with the development of the Member's ICP.

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

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

- High-risk pregnancy, including Members with a history of a previous preterm delivery.
- Catastrophic or end-stage medical conditions (e.g. neoplasm, organ/tissue transplants, End Stage Renal Disease).
- Comorbid chronic illnesses (e.g. asthma, diabetes, COPD, Congestive Heart Failure [CHF], etc.).
- Preterm births.
- High-technology home care requiring more than two weeks of treatment.
- Member accessing emergency department services inappropriately.
- Children with Special Health Care Needs.

Referrals to the ICM program may be made by contacting Molina at:
Phone: (866) 774-1510

The ICM Program provides care coordination and health education for disease management, as well as identifies and addresses psychosocial barriers to accessing care with the goal of promoting high quality care that aligns with a Member's individual health care goals. Care Management focuses on the delivery of quality, cost-effective, and appropriate health care services for Members who have been identified for Molina's ICM program. 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 case manager. Additionally, functional, social support and health literacy deficits are assessed, as well as safety concerns and caregiver needs. To initiate the care management process, the Member is screened for appropriateness for ICM program enrollment using specified criteria.

1. **The role of the Care Manager includes:**
    - Coordination of quality and cost-effective services.
    - Appropriate application of benefits.
    - Promotion of early, intensive interventions in the least restrictive setting of the Member's choice.
    - Assistance with transitions between care settings and/or Providers.
    - Provision of accurate and up-to-date information to Providers regarding completed health assessments and care plans.
    - Creation of ICPs, updated as the Member's conditions, needs and/or health status change.
    - Facilitation of Interdisciplinary Care Team (ICT) meetings, as needed.
    - Promote utilization of multidisciplinary clinical, behavioral and rehabilitative services.
    - Referral to and coordination of appropriate resources and support services, including but not limited to Managed Long-Term Services & Supports (MLTSS).
    - Attention to Member preference and satisfaction.
    - Attention to the handling of Protected Health Information (PHI) and maintaining confidentiality.

- Provision of ongoing analysis and evaluation of the Member's progress towards ICP adherence.
- Protection of Member rights.
- Promotion of Member responsibility and self-management.

2. **Referral to Care Management may be made by any of the following entities:**
   - Member or Member's designated representative(s)
   - Member's Primary Care Provider
   - Specialists
   - Hospital Staff
   - Home Health Staff
   - Molina Staff

Y. Specialty Pharmaceuticals/Injectable and Infusion Services

For information on Specialty Pharmaceuticals/Injectable and Infusion Services see the Specialty Pharmaceuticals, Injectable and Infusion Services section in the Pharmacy section.

VII. MyCare Ohio: Health Care Services

Health Care Services is comprised of Utilization Management (UM) and Care Management (CM) Departments that work together to achieve an integrated approach to coordinating care. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. Molina provides care management services to Members to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services.

A. Utilization Management (UM)

The Molina Utilization Management program provides pre-service authorization, inpatient authorization management, and concurrent review of inpatient and continuing services. Molina aims to ensure that services are medically necessary and an appropriate use of resources for the Member. Some of the elements of the UM program are:

- Evaluating the Medical Necessity and efficiency of health care services across the continuum of care.
- Applying appropriate criteria based on CMS guidelines and, when applicable, state requirements.
- Providing pre-admission, admission, and inpatient hospital and SNF review.
- Ensuring that services are available in a timely manner, in appropriate settings.
- Ensuring that qualified health care professionals are engaged in the UM decision-making process when appropriate.
- Ensuring the appropriate application of Member benefit coverage and coverage criteria.

- For dual eligible Members:
  - If Prior Authorization (PA) is submitted to Molina for any non-covered benefits, Molina will inform the Provider on who, including their contact information, the PA should be submitted to via denial notification.

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

Medical Necessity Review

Molina only reimburses for services that are Medically Necessary. Medical necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively. Medical Necessity decisions are made by a physician or other appropriate licensed health care personnel with sufficient medical expertise and knowledge of the appropriate coverage criteria. These medical professionals conduct Medical Necessity reviews in accordance with CMS guidelines (such as national and local coverage determinations) and use nationally recognized evidence based guidelines, third party guidelines, guidelines from recognized professional societies, and peer reviewed medical literature, when appropriate. Providers may request to review the criteria used to make the final decision.

Requesting Prior Authorization

Contracted Providers are responsible for requesting prior authorization of services when required by Molina policy, which may change from time to time. Failure to obtain prior authorization before rendering a service may result in a pre-service denial with Provider liability and/or denial of the Claim. The Member cannot be billed when a contracted Provider fails to follow the UM requirements for the Molina plan, including failure to obtain prior authorization before the Member receives the item or service. Obtaining authorization does not guarantee payment. Molina retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, correct coding, billing practices, and whether the service was provided in the most appropriate and cost effective setting of care.

Molina requires prior authorization for specified services. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS code. The prior authorization list is customarily updated quarterly, but may be updated more frequently, and is posted on the Molina Provider Website at MolinaHealthcare.com. The Prior Auth Lookup Tool is also available in the Molina Provider Portal.

Providers are encouraged to use the Molina Prior Authorization Request Form provided on the Molina Provider Website at MolinaHealthcare.com. If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Molina ID number, health plan).

- Provider demographic information (ordering Provider, servicing Provider, and referring Provider (when appropriate).
- Relevant Member diagnoses and ICD-10 codes.
- Requested items and/or services, including all appropriate CPT and HCPCS codes.
- Location where services will be performed (when relevant).
- Supporting clinical information demonstrating Medical Necessity under Medicare guidelines (and/or state guidelines when applicable).

Members and their authorized representatives may also request prior authorization of any item or service they want to receive. In this case, the physician or other appropriate Provider will be contacted to confirm the need for and specific details of the request.

Contracted Providers are expected to cooperate with Molina UM processes and guidelines, including submission of sufficient clinical information to support the Medical Necessity, level of care, and/or site of service of the items, and/or services requested. Contracted Providers must also respond timely and completely to requests for additional information. If Molina determines that a contracted Provider failed to follow the terms and conditions of the relevant Provider Contract or the Provider Manual, a denial may be issued with Provider liability. Members cannot be held responsible when the Provider fails to follow the terms and conditions of the relevant Provider Agreement or this Provider Manual. For information on the contracted Provider Claims appeals process see the Claim Reconsideration subsection located in the Claims and Compensation section of this Provider Manual.

Requests for prior authorization may be sent by telephone, fax, mail, or via the Provider Portal.

Provider Portal: Contracted Providers are encouraged to use the Provider Portal for prior authorization submissions whenever possible. Instructions for how to submit a prior authorization request are available on the Provider Portal. The benefits of submitting your prior authorization request through the Provider Portal are:

- Create and submit prior authorization requests.
- Check status of prior authorization requests.
- Receive notification of change in status of prior authorization requests.
- Attach all supporting medical documentation.

Phone: Prior authorizations can be initiated by contacting the appropriate Utilization Management Department at the number provided below. Supporting clinical information should be submitted by fax or via the Provider Portal for timely case processing.

For Advanced Imaging	(855) 714-2415
For Pharmacy (Part D and Part B drugs and for Medicaid-covered drugs when the Member is in an integrated plan providing Medicaid wrap benefits, such as a FIDE SNP or MMP)	(800) 665-3086

For all other Medicare MMP prior authorization requests (physical health and behavioral health)	(855) 322-4079

Fax: The Prior Authorization Request Form can be faxed to the appropriate UM Department at the number provided below:

For Advanced Imaging	(877) 731-7218
For Pharmacy (Part D and Part B drugs and for Medicaid-covered drugs when the Member is in an integrated plan providing Medicaid wrap benefits, such as a FIDE SNP or MMP)	Part D: (866) 290-1309 Part B (J-Codes): (800) 391-6437
For Medicare Hospital Inpatient Admission and Concurrent Review (physical health)	Fax: (844) 834-2152
For Medicare prior authorization (physical health and behavioral health)	Fax: (844) 251-1450

View the Prior Authorization Request Form for additional list of fax numbers by line of business and service type.

Mail: Prior authorization requests and supporting documentation can be submitted via U.S. Mail to the appropriate UM Department at the address provided below:

For Advanced Imaging	Molina Healthcare ATTN: Advanced Imaging 200 Oceangate, Suite 100 Long Beach, CA 90802
For Pharmacy (Part D and Part B drugs and for Medicaid-covered drugs when the Member is in an integrated plan providing Medicaid wrap benefits, such as a FIDE SNP or MMP)	Molina Healthcare ATTN: Medicare Pharmacy Dept. 7050 Union Park Avenue, STE 200 Midvale, UT 84047
For all other Medicare & MMP prior authorization requests (physical health and behavioral health)	Molina Healthcare ATTN: Medicare Utilization Management 200 Oceangate, Suite 100 Long Beach, CA 90802

Molina's Nurse Advice Line is available to Members and Providers 24 hours a day, 7 days a week at (855) 895-9986. Molina's Nurse Advice Line handles urgent and emergent after-hours UM calls. PCPs are notified via fax of all Nurse Advice Line encounters.

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

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

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

Affirmative Statement about Incentives

Health care professionals involved in the UM decision-making process base their decisions on the appropriateness of care and services and the existence of coverage. Molina does not specifically reward practitioners or other individuals for issuing denials of coverage or care and does not provide financial incentives or other types of compensation to encourage decisions that result in under-utilization or barriers to care.

Timeframes

Prior authorization decisions are made as expeditiously as the Member's health condition requires and within regulatory timeframes.

- Expedited Initial requests must be made as soon as medically necessary, within 48 hours (including weekends and holidays) following receipt of the validated request.
- Standard requests must be made as soon as medically indicated, within a maximum of 10 calendar days after receipt of request

A Provider may request that a UM decision be expedited if following the standard timeframe could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function. Providers must ask that a request be expedited only when this standard is supported by the Member's condition.

Communication of Pre-service Determinations

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone or fax.

When a pre-authorization request is denied with Member liability, the Member is issued a denial notice informing them of the decision and their appeal rights with a copy to the Provider. The Member's appeal rights are discussed further in the Appeals and Grievances section of this Provider Manual.

When a pre-authorization request is denied with Provider liability, the Provider is issued a denial notice by fax informing them of the decision. Additional information on the contracted Provider Claims appeal process can be found in the Claim Reconsideration subsection found in the Claims and Compensation section of this Provider Manual.

Peer-to-Peer Discussions and Re-openings

Molina abides by CMS rules and regulations for all organization determinations/pre-service authorization requests and will allow a peer-to-peer conversation in limited circumstances.

- While the request is being reviewed, but prior to a final determination being rendered.
- While an appeal of an Organizational Determination/pre-service authorization request is being reviewed.
- Before a determination has been made. If the Molina Medical Director believes that a discussion with the requesting physician would assist Molina in reaching a favorable determination (within the obligatory timeframes stated above for a standard or expedited request).

Upon receipt of an adverse inpatient/concurrent review determination, Network Providers(peer) may request a peer-to-peer discussion within five calendar days of the date on the authorization denial notification.

A “peer” is considered a physician, physician assistant, nurse practitioner, or PhD psychologist who is directly providing care to the Member or a Medical Director on site at the facility. Calls from EHR and other similar contracted external parties, administrators, or facility UM staff are not peers and calls will not be returned.

To make the Peer-to-Peer request:

- Call Molina Healthcare Utilization Management at (855) 322-4079 from 8:30 a.m. to 5 p.m., Monday to Friday.
- Include two possible dates and times a licensed professional is available to conduct the review with a Molina medical director.

If the Peer-to-Peer does not change the outcome of a determination, or is not requested within five calendar days, Providers may request an authorization reconsideration within 30 days of the date on the authorization denial notification or up until the claim denial for inpatient/concurrent services. The authorization reconsideration must include new/additional clinical information to be considered. Once a determination has been rendered for the authorization reconsideration, no further authorization reconsiderations are available. Please access the Authorization and Claim Reconsideration Reference Guides on the Provider Website for additional details regarding this process.

Once a final pre-service authorization adverse decision is made, however, the decision may not be reversed if Member liability is assigned (i.e., the Member is issued a denial notice with Medicare appeal rights) unless the CMS requirements for a reopening are met. CMS allows Medicare Advantage plans to use the reopening process only sparingly.

Requirements for a reopening include clear clerical error, the procurement of new and material evidence that was not available or known at the time of the decision that may result in a different conclusion, or evidence that was considered in making the decision clearly shows on its face that an obvious error was made at the time of the decision (i.e., the decision was clearly

incorrect based on all the evidence presented). Providers may not use the reopening process for the routine submission of additional information.

Re-openings are not allowed once an appeal is filed by the Provider or the Member (or their authorized representative). Molina Medical Directors are available prior to the time of the decision to discuss any unique circumstances to be considered in the case.

Medicare says that if Molina, being a Medicare Advantage plan, decides to not provide or pay for a requested service, in whole or in part, then an adverse Organization Determination (denial) has occurred and we must issue a written denial notice. Once the notice has been mailed or faxed to you, or the Member, or Molina has phoned the Member and/or you, advising that there has been an adverse Organization Determination (denial), the appeals process then becomes available to you.

If you wish to dispute Molina's adverse Organization Determination (denial) we may only process the request by following the Standard or Expedited appeal process. This means that if you contact Molina to request a Peer-to-Peer review, we will advise you that you must follow the rules for requesting a Medicare appeal. Refer to the Complaints, Member Grievances and Appeals section of this Provider Manual.

Adverse decisions for which only Provider liability is assigned and that do not involve an adverse determination or liability for the Member may be subject to a peer-to-peer conversation. A peer-to-peer conversation is an opportunity to clarify the clinical information or to provide newly discovered clinical information. Molina will not allow contracted Providers to use the peer-to-peer process as a vehicle for routine failure to provide sufficient information in the UM process or to avoid the contracted Provider Claims appeals process. Contracted Providers are responsible for providing all information to support the request within the required timeframes. Additional information on the contracted Provider Claims appeals process can be found in the Claim Reconsideration subsection found in the Claims and Compensation section of this Provider Manual.

Open Communication About Treatment

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

Molina and its contracted Providers may not enter into contracts that interfere with any ethical responsibility or legal right of Providers to discuss information with a Member about the

Member's health care. This includes, but is not limited to, treatment options, alternative plans or other coverage arrangements.

Utilization Management Functions Performed Exclusively by Molina

The following UM functions are conducted by Molina and are **never delegated**:

1. **Transplant -** Molina does not delegate management of transplant cases to the medical group. Providers are required to notify Molina's UM Department (Transplant Unit) when the need for a transplant evaluation is identified. Contracted Providers must obtain prior authorization from Molina Medicare for transplant evaluations and surgery. Upon notification, Molina conducts Medical Necessity review. Molina selects the facility to be accessed for the evaluation and possible transplant.
2. **Clinical Trials -** Molina does not delegate to Providers the authority to authorize payment for services associated with clinical trials. See Clinical Trials below for additional information.
3. **Experimental and Investigational Reviews -** Molina does not delegate to Providers the authority to determine and authorize experimental and investigational reviews.

Clinical Trials

National Coverage Determination (NCD) 310.1 provides that Medicare covers the routine costs of qualifying clinical trials (as defined in the NCD) as well as reasonable and necessary items, and services used to diagnose and treat complications arising from participation in all clinical trials. All other Medicare rules apply. Routine costs of a clinical trial include all items and services that are otherwise generally available to Medicare beneficiaries that are provided in either the experimental or control arm of a clinical trial except:

- The investigational item or service itself unless otherwise covered outside of the clinical trial;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct management of the patient; and
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the clinical trial.

Routine costs in clinical trials include:

- Items or services that are typically provided absent a clinical trial;
- Items or services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, and in particular for the diagnosis or treatment of complications.

For non-covered items and services, including items and services for which Medicare payment is statutorily prohibited, Medicare only covers the treatment of complications arising from the delivery of the non-covered item or service and unrelated to reasonable and necessary care. However, if the item or service is not covered by virtue of a national non-coverage policy (i.e., an NCD) and is the focus of a qualifying clinical trial, the routine costs of the clinical trial will be covered by Medicare but the noncovered item or service itself will not.

Clinical trials must meet qualifying requirements. Additional information on these requirements and the qualifying process can be found in NCD 310.1.
If the Member participates in an unapproved study, the Member will be liable for all costs associated with participation in that study. Members can obtain additional information about coverage for the costs associated with clinical trials and Member liability for Medicare cost-sharing amounts in their or Member Handbook.

Delegated Utilization Management Functions

Molina may delegate UM functions to qualifying Medical Groups/IPAs and delegated entities. These entities are required to perform these functions in compliance with all current Molina policies and regulatory and certification requirements. For more information about delegated UM functions and the oversight of such delegation, please refer to the Delegation section of this Provider Manual.

Emergency Services, Urgent Care, and Post-Stabilization Services

Molina covers Emergency Services as well as Urgently Needed Services and Post-Stabilization Care for Members in accordance with applicable federal and state law.
Medicare defines Emergency Services are covered services provided to evaluate or treat an Emergency Medical Condition. An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Serious jeopardy to the health of the individual or, in the case of a pregnant Member, the health of the Member or their unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Urgently Needed Services are Covered Services that:

1. Are not Emergency Services, but are Medically Necessary and immediately required as a result of an unforeseen illness, injury, or condition;
2. Are provided when (a) the Member is temporarily absent from the Molina plan's service area and therefore, the Member cannot obtain the needed service from a network Provider; or (b) when the Member is in the Molina plan's service area but the network is temporarily unavailable or inaccessible; and

3. Given the circumstances, it was not reasonable for the Member to wait to obtain the needed services from their regular plan Provider after returning to the service area or the network becomes available.

Post-Stabilization Care Services are Covered Services that are:
1. Related to an Emergency Medical Condition;
2. Provided after the Member is stabilized; and
3. Provided to maintain the stabilized condition, or under certain circumstances, to improve or resolve the member's condition.

Emergency Services and Urgently Needed Services do not require pre-authorization, although contracted Provider notification requirements may apply. See Emergency Inpatient Admissions below.

Members over-utilizing the emergency department may be contacted by Molina Care Managers to provide assistance whenever possible and determine the reason for using Emergency Services.

Inpatient Admission Notification and Management

Elective Inpatient Admissions

Molina requires prior authorization for all elective/scheduled inpatient admissions and procedures to any inpatient facility (i.e., including hospitals, SNFs, and other inpatient settings). Contracted SNFs, long-term acute care hospitals (LTACHs), and acute inpatient rehabilitation (AIR) facilities/units must obtain prior authorization before admitting the Member.

Inpatient facilities are also required to notify Molina of the admission within 24 hours or by the following business day or as otherwise specified in the relevant Provider Agreement. Inpatient notifications may be submitted by fax. Contact telephone numbers and fax numbers are provided in the Requesting Prior Authorization section of this Provider Manual.

Continued stay must be supported by clinical documentation supporting the level of care. Failure to obtain prior authorization, to provide timely notice of admission, or to support the level of care may result in denial with Provider liability. Members cannot be held liable for failure of a contracted Provider to follow the terms of the relevant Provider Agreement and this Provider Manual. Additional information on the contracted Provider Claims appeal process can be found in the Claim Reconsideration subsection found in the Claims and Compensation section of this Provider Manual.

Emergent Inpatient Admissions

Molina requires notification of all emergent inpatient admissions within 24 hours of admission or by the following business day or as otherwise specified in the relevant Provider Agreement.

Notification of admission is required to verify eligibility, authorize care, including level of care, and initiate concurrent review and discharge planning. Notification must include Member demographic information, facility information, date of admission, and clinical information supporting the level of care. Notifications may be submitted by fax. Contact telephone numbers and fax numbers are noted in the Requesting Prior Authorization section of this Provider Manual.

Prior authorization is not required for an observation level of care. Once the Member is stabilized and a request for inpatient admission is made or the observation period expires, contracted Providers are responsible for supporting an admission level of care. Failure to provide timely notice of admission or to support an admission level of care may result in a clinical level of care denial with Provider liability. Members cannot be held liable for a contracted Provider's failure to follow the terms of the relevant Provider Agreement and this Provider Manual. Additional information on the contracted Provider Claims appeal process can be found in the Claim Reconsideration subsection found in the Claims and Compensation section of this Provider Manual.

Inpatient at Time of Termination of Coverage

Members hospitalized on the day that Member in the Molina plan terminates are usually covered through discharge. Specific Molina plan rules and Provider Agreement provisions may apply.

NOTICE Act

Under the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), hospitals (including critical access hospitals) must deliver the Medicare Outpatient Observation Notice (MOON) to any beneficiary (including a Medicare Advantage enrollee) who receives observation services as an outpatient for more than 24 hours. The MOON is issued to inform the beneficiary that they are an outpatient receiving observation services and not a hospital inpatient. The beneficiary is informed that their services are covered under Part B and that Part B cost-sharing amounts apply. Additional information is provided to the beneficiary with regard to how an observation stay may affect their eligibility for a SNF level of care and that Part B does not cover self-administered drugs.

Inpatient Concurrent Review

Molina performs concurrent inpatient review to ensure Medical Necessity of ongoing inpatient services, adequate progress of treatment, and development of appropriate discharge plans. Concurrent review is performed for inpatient stays regardless of setting (i.e., including hospital, SNF, and other inpatient setting), although the cadence and extent of concurrent review may vary depending on the setting and the Member's circumstances. Performing these functions requires timely clinical. Molina will request updated clinical records from inpatient facilities at

regular intervals during a Member's inpatient stay. Requested clinical updates must be received from the inpatient facility within 24 hours of the request or such other time as may be indicated in the request.

Failure to provide timely clinical updates may result in denial of authorization for the remainder of the inpatient admission with Provider liability dependent on the circumstances and the terms of the relevant Provider Agreement. Members cannot be held liable for a contracted Provider's failure to follow the terms of the relevant Provider Agreement or this Provider Manual.

Molina will authorize hospital care as an inpatient when the clinical record supports the Medical Necessity of continued hospital stay. An observation level of care should be provided first when appropriate. Upon discharge, the Provider must provide Molina with a copy of Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

Discharge Planning

The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission. UM staff work communicate with hospital discharge planners to determine the most appropriate discharge setting for our Members. The clinical staff review Medical Necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), SNF, and rehabilitative services.

Readmissions

Readmission review is important to ensure that Molina Members are receiving hospital care that is compliant with nationally recognized guidelines as well as federal and state regulations.

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

When a subsequent admission to the same facility occurs within 2-30 days of discharge, and it is determined that the subsequent readmission is related to the first admission (readmission) and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

Out-of-Network Providers and Services

Molina maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process. Molina requires Members to receive non-emergency medical care within the participating, contracted network of Providers. Services

provided by non-contracted Providers must be prior authorized. Exceptions include Emergency Services and Medically Necessary dialysis services obtained by the Member when they are outside the service area. See the section on Emergency Services, Urgent Care, and Post-Stabilization Services above. When no exception applies, Molina will determine whether there are contracted Providers within the service area willing and able to provide the items or services requested for the Member.

Termination of Ongoing Services

Termination of Inpatient Hospital Services

Hospitals are required by CMS regulations to deliver the Important Message (IM) from Medicare (IM, Form CMS-10065), to all Medicare beneficiaries (including Medicare Advantage enrollees) who are hospital inpatients within two calendar days of admission. This requirement is applicable to all hospitals regardless of payment type or specialty. Delivery must be made to the Member or the Member's authorized representative in accordance with CMS guidelines. A follow-up copy of the IM is delivered no more than two calendar days before the planned discharge date.

The IM informs beneficiaries of their rights as a hospital inpatient, including their right to appeal the decision to discharge. Hospitals must deliver the IM in accordance with CMS guidelines and must obtain the signature of the beneficiary or their representative and provide a copy at that time. When the Member is no longer meeting criteria for continued inpatient stay and the hospital has not initiated discharge planning, Molina may require that the hospital issue a follow-up copy of the IM and notify the Member of their discharge date or provide additional clinical information supporting an inpatient level of care. Failure to do so may result in the denial of continued hospital services with Provider liability. The Member cannot be held liable for any continued care (aside from any applicable deductibles or copayments) without proper notification that includes their appeal rights located within the IM and if the Member exercises their appeal rights, not until noon of the day after the Quality Improvement Organization (QIO) notifies the Member of a determination adverse to the Member.

When the Member exercises their appeal rights with the QIO, the hospital is required to properly complete and deliver the Detailed Notice of Discharge (DND, Form CMS-10066) to the QIO and the Member as soon as possible and no later than noon follow the day of the QIO's notification to the hospital of the appeal. The hospital is also required to provide all information that the QIO requires to makes its determination. At the Member's request, the hospital must provide to the Member a copy of all information provided to the QIO, including written records of any information provided by telephone. This documentation must be provided to the Member no later than close of business of the first day that the Member makes the request.

The exhaustion of a Member's covered Part A hospital days is not considered to be a discharge for purposes of issuing the IM.

Termination of SNF, CORF, and HHA Services

The Notice of Medicare Non-Coverage (NOMNC) is a statutorily required notice issued to Medicare beneficiaries to inform them of the termination of ongoing services (discharge) by a SNF (including hospital swing beds providing Part A and Part B services), comprehensive outpatient rehabilitation facility (CORF) or home health agency (HHA). The NOMNC also provides the beneficiary with their appeal rights for the termination of services. The NOMNC must be delivered to the Member or the Member's authorized representative in accordance with CMS guidelines and at least two days prior to discharge (or the next to the last time services are furnished in the case of CORF or HHA services).

When Molina makes a determination that the Member's continued services are no longer skilled and discharge is appropriate, a valid NOMNC is sent to the contracted Provider (SNF, CORF, or HHA) for delivery with a designation of the last covered day. Contracted Providers are responsible for delivering the NOMNC on behalf of Molina to the Member or Member representative and for obtaining signature(s) in accordance with CMS guidelines. The contracted Provider must provide Molina with a copy of the signed NOMNC. If the Member appeals the discharge to the QIO, the contracted Provider must also provide the QIO with a signed copy of the NOMNC and all relevant clinical information. The Member cannot be held liable for any care (aside from any applicable deductibles or copayments) without proper notification that includes their appeal rights located in the NOMNC and if the Member exercises their appeal rights, not before the appeal process with the QIO is complete. If the QIO's decision is favorable to the Member, the Member cannot be held liable until a proper NOMNC is issued and the Member is given their appeal rights again. Failure of the contracted Provider to complete the notification timely and in accordance with CMS guidelines or to provide information timely to the QIO may result in the assignment of Provider liability. Members cannot be held responsible for the contracted Provider's failure to follow the terms of the relevant Provider Agreement or the Provider Manual.

A NOMNC is not issued in the following instances:

- When services are reduced (e.g., when a Member is receiving physical therapy and occupational therapy from a home health agency and only the occupational therapy is terminated);
- When the Member moves to a higher level of care (e.g., from home health to SNF);
- When the Member exhausts their Medicare benefit;
- When the Member terminates services on their own initiative;
- When the Member transfers to another Provider at the same level of care (e.g., a move from one SNF to another while remaining in a Medicare-covered stay); or
- When the Provider terminates services for business reasons (e.g., the Member is receiving home health services but has a dangerous animal on the premises).

Coordination of Care and Services

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

Molina staff provides 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.

Providers must offer the opportunity to provide assistance to identified Members through:

- Notification of community resources, local or state funded agencies.
- Education about alternative care.
- How to obtain care as appropriate.

Continuity of Care and Transition of Members

It is Molina's policy to provide Members with advance notice when a Provider they are seeing will no longer be in network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the Provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out-of-network Provider for a given period of time and provide continued services to Members undergoing a course of treatment by a Provider that has terminated their contractual agreement if the following conditions exist at the time of termination.

- Acute condition or serious chronic condition – Following termination, the terminated Provider will continue to provide Covered Services to the Member up to 90 days or longer if necessary, for a safe transfer to another Provider as determined by Molina or its delegated Medical Group/IPA.
- High risk of second or third trimester pregnancy – The terminated Provider will continue to provide services following termination until postpartum services related to delivery are completed or longer if necessary, for a safe transfer.

For additional information regarding continuity of care and transition of Members, please contact Molina at (855) 322-4079.

Continuity and Coordination of Provider Communication

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

Reporting of Suspected Abuse and/or Neglect:

A vulnerable adult is a person who is receiving or may be in need of receiving community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of themselves, or unable to protect themselves against significant harm or exploitation. When working with children one may encounter situations suggesting abuse, neglect and/or unsafe living environments.

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

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

Suspected abuse and/or neglect should be reported as follows:

Child Abuse:

The Ohio Department of Job and Family Services has launched 855-O-H-Child (855-642-4453), an automated telephone directory that will link callers directly to a child welfare or law enforcement office in their county.

Adult Abuse:

Adult protective services for adults age 60 and older can be reached at the Ohio Department of Job and Family Services at 855-OHIO-APS (855-644-6277).

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

Molina will follow up with Members who 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.

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

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

Primary Care Providers

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

Referrals to specialty care outside the network require prior authorization from Molina. Molina will assist in ensuring access for second opinions from network and out-of-network Providers as well, as applicable.

B. Care Management (CM)

The Integrated Care Management (ICM) Program provides care coordination and health education for disease management, as well as identifies and addresses psychosocial barriers to accessing care with the goal of promoting high quality care that aligns with a Member's individual health care goals. Care Management focuses on the delivery of quality, cost-effective, and appropriate health care services for Members. 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 more intensive support and education from a care manager. Additionally, functional, social support, and health literacy deficits are assessed, as well as safety concerns and caregiver needs.

1. **The role of the Care Manager includes:**

- Coordination of quality and cost-effective services.
- Appropriate application of benefits.
- Promotion of early, intensive interventions in the least restrictive setting of the Member's choice.
- Assistance with transitions between care settings and/or Providers.
- Provision of accurate and up-to-date information to Providers regarding completed health assessments and care plans.
- Creation of ICPs, updated as the Member's conditions, needs and/or health status change.
- Facilitation of Interdisciplinary Care Team (ICT) meetings as needed.
- Promote utilization of multidisciplinary clinical, behavioral and rehabilitative services.
- Referral to and coordination of appropriate resources and support services, including but not limited to Managed Long-Term Services & Supports (MLTSS).
- Attention to Member preference and satisfaction.
- Attention to the handling of Protected Health Information (PHI) and maintaining confidentiality.
- Provision of ongoing analysis and evaluation of the Member's progress towards ICP adherence.
- Protection of Member rights.
- Promotion of Member responsibility and self-management.

2. **Referral to Care Management may also be made by the following entities:**

- Member or Member's designated representative(s)
- Member's Primary Care Provider
- Specialists
- Hospital Staff
- Home Health Staff
- Molina staff

VIII. Managed Long-Term Services and Support (MLTSS)

MLTSS Overview

MLTSS includes both Long-Term Care (LTC) and Home and Community-Based Services (HCBS). Long-Term Care programs are when an individual is living in a facility-based care setting (such as a nursing home or intermediate care facility). Home and community-based services programs provide alternatives to living in facility-based care settings. These programs empower consumers to take an active role in their health care and to remain in the community. Both programs serve people who are older adults, people with intellectual and/or developmental disabilities, or people with physical disabilities.

Molina understands the importance of working with our local Providers and Community Based Organizations (CBOs) to ensure our Members receive MLTSS services that maintain their independence and ability to remain in the community.

Molina's MLTSS Provider network is a critical component to ensuring our Members receive the right care, in the right place, at the right time. The following information has been included to help support our MLTSS Provider network and achieve a successful partnership in serving those in need.

MLTSS Services and Molina

Molina serves the following counties in the MyCare Ohio Program: Delaware, Franklin, Pickaway, Union, Madison, Clark, Greene, Clinton, Montgomery, Warren, Clermont, Butler and Hamilton.

Nursing Facility-Based (NF-Based) Level of Care (LOC)

MLTSS Services require a NF-Based LOC. This LOC includes the Intermediate and Skilled LOC:

- **Intermediate LOC** includes a need for assistance with activities of daily living, medication administration and/or a need for at least one skilled nursing or skilled rehabilitation service.
- **Skilled LOC** indicates a higher level of need than the Intermediate LOC and includes presence of an unstable medical condition and a need for a specific amount of skilled nursing or skilled rehabilitation services.

A Member must meet NF-Based LOC to receive long-term care services in a nursing facility or to enroll on the MyCare Waiver.

The MyCare Waiver, also known as the MyCare Ohio Waiver, or as the Integrated Care Delivery System (ICDS) Waiver program encompasses the services offered under the Ohio Home Care, PASSPORT and Assisted Living Waivers, and is designed to help meet the needs of people who are:

- Financially eligible for Medicaid.
- Enrolled in the MyCare Ohio program.
- Have been assessed to require an Intermediate or Skilled LOC.
- Are age 18 or older.

Note: A person may not be eligible for the Ohio Department of Aging (ODA) and ODM administered HCBS Waivers if receiving, or qualify for, developmental disabilities (DD) waiver services.

MLTSS Benefits and Approved Services

Ohio Administrative Code (OAC) 5160-58-04 MyCare Ohio waiver: covered services and providers:

- Adult day health services as set forth in rule 173-39-02.1 or 5160-46-04
- Alternative meal services as set forth in rule 173-39-02.2
- Assisted living services as set forth in rule 173-39-02.16
- Choices home care attendant services as set forth in rule 173-39-02.4
- Community integration services as set forth in rule 173-39-02.15 or 5160-44-14
- Community transition services as set forth in rule 173-39-02.17 or 5160-44-26
- Enhanced community living services as set forth in rule 173-39-02.20
- Homemaker services as set forth in rule 173-39-02.8
- Home care attendant services as set forth in rule 173-39-02.24 or 5160-44-27
- Home-delivered meal services as set forth in rule 173-39-02.14 or 5160-44-11
- Home maintenance and chore services as set forth in rule 173-39-02.5 or 5160-44-12
- Home medical equipment and supplemental adaptive and assistive devices services as set forth in rule 173-39-02.7 or 5160-46-04
- Home modification services as set forth in rule 173-39-02.5 or 5160-44-13
- Nutrition consultation services as set forth in rule 173-39-02.10
- Out-of-home respite services as set forth in rule 173-39-02.23 or 5160-44-17
- Personal care aide services as set forth in rule 173-39-02.11 or 5160-46-04
- Personal emergency response services as set forth in rule 173-39-02.6 or 5160-44-16
- Social work counseling services as set forth in rule 173-39-02.12
- Waiver nursing services as set forth in rule 173-39-02.22 or 5160-44-22
- Waiver transportation services as set forth in rules 173-39-02.13 and 173-39-02.18 or 5160-46-04

Getting Care, Getting Started

The Area Agency on Aging (AAA) determines a Member's eligibility for the MyCare Waiver. When a client contacts the AAA or a referral is completed by a Molina Care Manager for the MyCare Waiver, an intake coordinator will assess the need and provide the resources the Member is requesting and is eligible to receive. The intake coordinator will schedule a LOC assessment to be completed with the Member.

NOTE: Ohio has 12 AAAs that collectively represent all 88 counties. Ohio AAAs are designated by the ODA.

The AAA office that is designated for each of the counties represented in the Molina Dual Options MyCare Ohio, a Medicare-Medicaid Plan Program are:

- **Central Ohio Area Agency on Aging (COAAA), AAA6**
  Serving: Delaware, Franklin, Madison, Pickaway and Union counties

Phone: (614) 645-7250
Address: 3776 South High Street
Columbus, OH 43207

- **Council on Aging of Southwestern Ohio (COA), AAA1**
  Serving: Butler, Clermont, Clinton, Hamilton and Warren counties
  Phone: (513) 721-1025
  Address: 175 Tri County Parkway
  Cincinnati, OH 45246
- **Area Agency on Aging for West Central Ohio, AAA2**
  Serving: Clark, Greene and Montgomery Counties
  Phone: (937) 223-4357
  Address: 40 W. Second Street, Suite 400
  Dayton, OH 45402

Molina contracts with the Area Agency on Aging (AAA) to provide waiver service coordination for Members age of 60 and older. Members age 60 and over may select their Waiver Service Coordinator entity as either the AAA or Molina. If the Member is age 59 and younger, Molina will automatically be the Waiver Service Coordinator. The Care Manager and Waiver Service Coordinator may be the same individual.

The Molina Care Manager and Waiver Service Coordinator will engage with Members and routinely assess for barriers and opportunities to coordinate medical, behavioral health and MLTSS services. Specifically, along with providing the fully-integrated Individualized Care Plan (ICP), the Care Manager and Waiver Service Coordinator provide verbal, written and/or alternate format information on:

- After-hours assistance for urgent situations.
- Access to timely appointments.
- Accommodations available to meet individual linguistic, literacy, and preferred modes of communication.
- Advocacy, engagement of family Members and informal supports.

At a minimum, the Care Manager and Waiver Service Coordinator names, contact information is included in the Person-Centered Service Plan, which is shared with all Interdisciplinary Care Team (ICT) participants based on a Member's recorded preferences. All Care Managers and Waiver Service Coordinators are required to keep email and voicemail current with availability or backup as necessary for Members and their Providers.

Molina will ensure the provision of the following service coordination services for the Members:

- MLTSS Waiver Service Coordination/Care Management
- Care and Service Plan Review
- Crisis Intervention

- Event Based Visits
- Institution-based Visits
- Service Management
- Medicaid Resolution
- Assessment of MLTSS Need
- Member Education

After the member's needs have been determined, Molina will work closely with the various Community-Based Organizations (CBOs) for Home and Community-Based Services (HCBS) to ensure that the Member is getting the care that they need.

Once you have been identified as the Provider of service, it will be your responsibility for billing of these services. The Person-Centered Service Plan will document services, duration and any other applicable information.

Care Management/ICT

All Members enrolled in MyCare Ohio will receive Care Management and be assigned a Care Manager from Molina.

The Care Management team for MLTSS will include, at a minimum, the Member and/or their authorized representative, Care Manager, Waiver Service Coordinator and Primary Care Provider (PCP).

The person-centered ICT will include, at minimum, the Member and/or their authorized representative, the PCP, the Care Manager, the Waiver Service Coordinator and anyone the Member requests to participate. ICT members may also include MLTSS Providers (e.g. Services Facilitator, Adult Day Health Care Center staff, transition coordinator, Nursing Facility staff, etc.), specialist(s), behavioral health clinician and pharmacist. The ICT can also include family/caregivers, peer supports, or other informal supports and is not limited to the list of required members.

Individualized Care Plan Coordination

MLTSS services to be covered by Molina will require coordination and approval.

The ICP includes the consideration of medical, behavioral, and long-term care needs of the Member identified through a person-centered assessment process. The ICP includes informal care, such as family and community support. Molina will ensure that a person-centered service plan is implemented for the Member in compliance with the Department of Health and Human Services HCBS final rule section 441.301.

A Person-Centered Service Plan refers to the plan that documents the amount, duration and scope of the home and community-based services. The Person-Centered Service Plan must

reflect the services and supports important for the individual Member to meet their needs, goals and preferences which are identified through assessment of Member need. The service plan will also identify what is important regarding the delivery of these services and supports (42 CFR 441.301).

The ICP will be developed under the Member's direction and implemented by the assigned Members of the ICT no later than the end date of any existing Service Authorization or within the state-specific timeframes for initial assessments and reassessments. This applies to the MyCare Waiver. All services and changes to services must be documented in the ICP and be under the direction of the Member in conjunction with the Care Manager and Waiver Service Coordinator.

The ICT under Member's direction is responsible for developing the ICP and is driven by and customizable according to the needs and preferences of the Member. As a Provider you may be asked to be part of the ICT.

Additional services can be requested through the Member's Care Manager and Waiver Service Coordinator at any time; including during the assessment process and through the ICT process. Additional services needed must be at the Member's direction and can be brought forward by the Member, the Care Manager, and/or the ICT as necessary. Once an additional need is established, the care plan will be updated with the Member's consent and additional services approved.

Transition of Care Programs, Policies and Requirements

Molina has processes and systems in place to ensure smooth transitions between each Member's setting of care and level of care. This includes transitions to and from inpatient settings (i.e. Nursing Facility to Home).

All Care Managers and Waiver Service Coordinators are trained on the transitions of care approach that Molina follows for transitions between care settings. The care coordinators facilitate on-site, in-person, and home-based assessments that are housed in an electronic health management platform.

Continuity of Care (COC) Policy and Requirements

Transition Requirements	HCBS Waiver Beneficiaries	Non-Waiver Beneficiaries with Long-Term Care (LTC) Needs Home Health (HH) and Private Duty Nurse (PDN) use	Nursing Facilities (NF) Beneficiaries Assisted Living (AL) Beneficiaries	Beneficiaries not identified for LTC Services
Physician	90-day transition for members	90-day transition for members identified for	90-day transition for members identified for	90-day transition for members identified

Transition Requirements	HCBS Waiver Beneficiaries	Non-Waiver Beneficiaries with Long-Term Care (LTC) Needs Home Health (HH) and Private Duty Nurse (PDN) use	Nursing Facilities (NF) Beneficiaries Assisted Living (AL) Beneficiaries	Beneficiaries not identified for LTC Services
	identified for high-risk care management; 365 days for all others	high-risk care management; 365 days for all others	high-risk care management; 365 days for all others	for high-risk care management; 365 days for all others
DME	Must honor Prior Authorizations (PAs) when item has not been delivered and must review ongoing PAs for medical necessity	Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity	Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity	Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity
Scheduled Surgeries	Must honor specified provider	Must honor specified provider	Must honor specified provider	Must honor specified provider
Chemotherapy/ Radiation	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider	Must honor specified provider	Must honor specified provider	Must honor specified provider
Dialysis Treatment	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider
Vision and Dental	Must honor PAs when item has not been delivered	Must honor PAs when item has not been delivered	Must honor PAs when item has not been delivered	Must honor PAs when item has not been delivered

Transition Requirements	HCBS Waiver Beneficiaries	Non-Waiver Beneficiaries with Long-Term Care (LTC) Needs Home Health (HH) and Private Duty Nurse (PDN) use	Nursing Facilities (NF) Beneficiaries Assisted Living (AL) Beneficiaries	Beneficiaries not identified for LTC Services
Medicaid HH and PDN	Maintain service at current level and with current providers at current Medicaid reimbursement rates; Changes may not occur unless: 1) A significant change occurs as defined in OAC 5160-45-01, or 2) member expresses a desire to self-direct services, or after 365 days	Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation	For AL: Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation	N/A
Assisted Living Waiver Service			Provider maintained at current rate for the life of demonstration	
Medicaid Nursing Facility Services			Provider maintained at current Medicaid rate for the life of demonstration	
Direct Care Waiver Services	Maintain service at current level and with current providers at current Medicaid reimbursement rates; Plan initiated changes may not occur unless: A significant change occurs as defined in OAC 5160-45-01, or member expresses a desire to self-direct	N/A	N/A	N/A

Transition Requirements	HCBS Waiver Beneficiaries	Non-Waiver Beneficiaries with Long-Term Care (LTC) Needs Home Health (HH) and Private Duty Nurse (PDN) use	Nursing Facilities (NF) Beneficiaries Assisted Living (AL) Beneficiaries	Beneficiaries not identified for LTC Services
	services, or after 365 days			
All other Waiver Services	Maintain service at current level for 365 days and existing service provider at existing rate for 90 days; Plan initiated change in service provider can only occur after an in-home assessment and plan for the transition to a new provider	N/A	N/A	N/A
Medicaid Community Behavioral Health (BH) Organizations (Provider types 84 and 95)	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days; Medicaid rate applies during transition	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days; Medicaid rate applies during transition	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days; Medicaid rate applies during transition	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days; Medicaid rate applies during transition

Molina will allow for the safe transition of Members while adhering to minimal service disruption. In order to minimize service disruption, Molina will honor the Member's existing service plans. For the Assisted Living Waiver Service, the Provider will be maintained at current rate for the life of the MyCare demonstration. Direct Care Waiver Services will maintain service at current level and with current Providers at current Medicaid reimbursement rates. Plan initiated changes may not occur unless: A significant change occurs as defined in OAC 5160-45-01, the Member expresses a desire to self-direct services, or after 365 days. All other Waiver Services will maintain service at current level for 365 days and existing service Provider at existing rate for 90 days. Plan initiated change in service Provider can only occur after the completion of an in-home assessment and plan for the transition to a new Provider.

Waiver of Origin:

- **Assisted Living Waiver Program** – Services provided are listed in OAC 5160-33-02 Definitions for the assisted living home and community-based services waiver (HCBS) program.
- **Ohio Home Care Waiver Program** – Services provided are listed in OAC 5160-46-04 Ohio home care waiver: definitions of the covered services and provider requirements and specifications**.**
- **PASSPORT (Pre-Admission Screening System Providing Options and Resources Today)** – Services provided are listed in OAC 5160-31-05 PASSPORT HCBS waiver program covered services.

NOTE: Keep in mind that after the initial TOC period has concluded, all benefits associated with the above waivers will now be included in one benefit, the MyCare Waiver Services Program.

Exceptions

During the transition period, change from the existing services, or Provider, can occur in any of the following circumstances:

- Member requests a change.
- Significant change in Member's status.
- Provider gives appropriate notice of intent to discontinue services to a Member.
- Provider performance issues are identified that affect a Member's health and welfare.

Plan-initiated change in a service Provider can only occur after the completion of an in-home assessment and development of a plan for the transition to a new Provider.

During the Transition Period

Existing Providers can continue to serve current Members who transition to MyCare Ohio. Providers will be working directly with participating MyCare Ohio Plans (MCOPs).

- At the time of enrollment, any additional services needed by the Member that are not already on the Member's person-centered service plan must be authorized by the MCP.
- MCPs will have their own processes for the approval of waiver services.
- A contract with the MCP is not necessary during the transition period. MCPs will reach out to Providers.
- Existing Providers must make authorization and payment arrangements directly with the MCP. Contact the MCP to make arrangements.

Ongoing Provider support and technical assistance will be provided; especially to community behavioral health, MLTSS Providers, and out-of-network Providers during the continuity of care period. All existing ICPs and Service Authorizations (SAs) will be honored during the transition period.

A Member's existing Provider may be changed during the transition period only in the following circumstances: (1) the Member requests a change; (2) the Provider chooses to discontinue providing services to a Member as currently allowed by Medicaid; (3) Molina or the Ohio Department of Medicaid identify Provider performance issues that affect a Member's health or welfare; or (4) the Provider is excluded under state or federal exclusion requirements.

Out-of-network Providers who are providing services to Members during the initial continuity of care period shall be contacted to offer information on how to become credentialed, in-network Providers with Molina. If the Provider chooses not to join the network, or the Member does not select a new in-network Provider by the end of the transition period, Molina will work with the Member in selecting an in-network Provider.

Members in a Nursing Facility at the time of Molina MLTSS enrollment may remain in that NF as long as the Member continues to meet nursing facility level of care, unless they or their family or authorized representative prefer to move to a different Nursing Facility or return to the community. The only reasons for which Molina may require a change in Nursing Facility is if (1) Molina or the Ohio Department of Medicaid identify Provider performance issues that affect a Member's health or welfare; or (2) the Provider is excluded under state or federal exclusion requirements.

For additional information regarding continuity of care and transition of MLTSS Members, please contact Molina at (855) 322-4079.

Self-Directed Care Services

Members have the choice of how their services are delivered through various models, which may include consumer-direction.

In a consumer-directed model, the state requires Molina maintain a contract with Public Partnerships (PPL) to serve as this financial management agency, also known as a fiscal intermediary. PPL will work with Members to handle the taxes, payroll and worker's compensation responsibilities of being an employer.

OAC 5160-58-04 MyCare Ohio waiver: covered services and Providers, paragraph (F)
The following services may be participant-directed using budget and/or employer authority. To exercise these authorities, Members must demonstrate the ability to direct Providers in accordance with paragraph (D) of rule 5160-58-03.2 of the Administrative Code:

1. Employer authority which includes, but is not limited to, the ability of the Member to hire, fire and train employees is available for the following services:
   a. Choices home care attendant services provided by a participant-directed individual Provider; and
   b. Personal care services provided by a participant-directed personal care Provider.

2. Budget authority which includes the ability of the Member to negotiate rates of reimbursement is available in the following services:
   a. Alternative meals;
   b. Choices home care attendant services;
   c. Home maintenance and chore services;
   d. Home modification services; and
   e. Home medical equipment and supplemental adaptive and assistive devices.

Self-directed services mean that participating Members or their representatives have decision-making authority over certain services and manage their services with supports, such as those provided by Public Partnerships (PPL). Under self-directed care, a Member is the "boss" and can hire and/or fire a Provider for violations of their contract. Self-directed services give Members and their families more flexibility, control and responsibility for managing all aspects of the Member's care.

A Waiver Care Manager will provide oversight to assist the Member with self-directed personal care. The Member also may choose an authorized representative to help with the day-to-day supervision of their service Provider and to assist with employer-related tasks.

All Member-directed personal care Providers are required to meet established training requirements, at the individual provider's expense, and to undergo criminal background checks prior to working for a PASSPORT Member. The pay rate for Member-directed care will be less than the current rate paid to agency Providers and will be paid at a set rate statewide. Federal law prohibits spouses, parents or legal guardians from being paid caregivers.

When a Member is already participating in self-directed care through a Medicaid waiver prior to enrolling in the ICDS Waiver, the current Provider with the same services, frequency and rates will remain for up to one year unless any of the following happens:

- There is no longer an assessed need for one of the services.
- The authorized representative is no longer able to fulfill the responsibilities of Member.
- There is no longer an authorized representative, if required.
- The health and well-being of the Member is affected, as determined by the waiver service coordinator.

Waiver Provider Signature Requirement

Waiver service Providers for the Assisted Living, MyCare, Ohio Home Care and PASSPORT waivers are required to sign the Member's person-centered service plan in order to meet Centers for Medicare and Medicaid Services (CMS) 42 CFR 441.301 rule and Ohio Department of Medicaid (ODM) requirements. The Provider's signature shows that the Provider acknowledges and agrees to provide the waiver service, as authorized in the person-centered service plan.

Providers who are affected by this requirement include those who are delivering "direct care" services including:

- Personal care
- Waiver nursing
- Home care attendant
- Out-of-home respite
- Enhanced community living
- Adult day services
- Social work counseling
- Independent living assistance

The direct care Provider's signature will be required when:

- The Provider receives a waiver service authorization for a new service.
- The waiver service authorization reflects a permanent change to a previously authorized service.

Credentialing and Contracting

Credentialing of MLTSS Providers is performed by the applicable AAA and contracting is performed by Molina. Molina is required to contract only with Providers who have been approved by the Ohio Department of Aging to perform a particular waiver service or set of services.

The regional AAAs determine if the organization wanting to provide waiver services has the capacity to meet all of the Conditions of Participation (OAC 173-39-02) and relevant Service Specifications (OAC 173-39-02.1 through 173-39-02.17). The Provider Relations Division of the AAA agency, which is charged with certifying and monitoring Providers, operates with a quality improvement approach. To determine capacity, the agency's Quality Improvement (QI) coordinators examine the Provider applicant's policies and procedures, documentation system, charting processes and delivery of direct Member services.

Who can apply to become an Ohio Department of Aging (ODA)-certified Provider?

Applicants must be legal businesses (either not-for-profit or for-profit) within the State of Ohio. All applicants must have provided, at the time of application, services to at least two individuals aged 60 years or older in the Central, Southwest and/or West Central Ohio area for a minimum of three months. The applicant must employ qualified staff and have written policies and procedures that support the Conditions of Participation and Service Specifications, as described below.

What are the Conditions of Participation and Service Specifications?

ODA, in consultation with ODM, the regional AAAs and service Providers, established the Conditions of Participation and Service Specifications as the standards by which all services must be delivered. They were designed to ensure the health, safety and welfare of each Member.

The Conditions of Participation (OAC 173-39-02) apply to all service Providers.
The Service Specifications (OAC 173-39-02.1 through 173-39-2.17) define and set the standards for individual PASSPORT services and apply only to Providers of those services.

There are no exceptions or waivers to the Conditions of Participation or Service Specifications, regardless of the size or the mission of the organization.

What does it mean to be a contracted Provider?

- Allows you to be published as a contracted Provider of the MCOP (Provider Directory, plan website, Medicaid Consumer Hotline).
- Establishes rate(s) of payment for your services and facilitates Molina's payment of claims.

Certification

As a condition of participation with Molina, a Provider must acquire and maintain ODM certification for the services it provides. If a Provider loses certification, immediate termination of the contract may result.

Loss of Certification/Contract termination process

If a Provider is no longer able to provide the approved services, the Provider must contact the Member's waiver service coordinator.

If a Provider is contracted with Molina for both medical and MLTSS services and wishes to discontinue the provision of MLTSS services and only provide medical services, the Provider must contact the Molina Contracting Department to update their specialty profile.

If a Provider wishes to terminate their contract, or if termination is required because the Provider has lost certifications, the Provider must contact Molina immediately.

Bidding Process

A bidding process will occur when there is a waiver service with no fee published on the Ohio Medicaid fee schedule. Molina has set fees for most services. If a service is needed for which Molina does not have a set fee, Molina will reach out to all appropriate Providers to request a bid.

Home Maintenance and Chore Services, Transportation, Home Modification, Home Medical Equipment and Supplemental Adaptive and Assistive Devices require bids.

Provider Compliance Oversight

Structural Compliance Reviews (SCR) will be conducted by either Public Consulting Group (PCG) or the PASSPORT Administrative Agency (PAA).

Providers must follow the current Conditions of Participation and Service Specification requirements of the Medicaid Waiver(s) for which they are certified/approved.

Each entity that pays claims, including Molina, will review Providers' documentation to verify that services authorized and paid for are actually provided.

Provider Complaints:

- Provider should work directly with Molina to resolve the issue.
- If the issue is not resolved, the Provider may submit a complaint to ODM at providercomplaints.ohiomh.com.
- For certification issues, the Provider should work with AAA or ODM to resolve.

Appeals, Grievances, and State Hearings

Molina maintains an organized and thorough grievance and appeal process to ensure timely, fair, unbiased and appropriate resolutions. Molina MLTSS Members, or their authorized representatives, have the right to voice a grievance or submit an appeal through a formal process.

Molina ensures that Members have access to the appeal process, by providing assistance throughout the whole procedure in a culturally and linguistically appropriate manner; including oral, written, and language assistance if needed. Grievance information is also included in the Member Handbook.

Member Grievances

For information on Member Grievances, read the Appeals and Grievances section of this Provider Manual.

Member Appeals

For information on Member Appeals, read the Appeals and Grievances section of this Provider Manual.

Member's Right to a State Fair Hearing

For information on Member's Right to a State Fair Hearing, read the Appeals and Grievances section of this Provider Manual.

Ombudsman

Long-term Care Ombudsmen safeguard Members who receive care services, advocating for quality care, investigating complaints and giving Members a voice.

Ombudsmen field complaints about long-term care services, voice Members' needs and concerns to nursing homes, home health agencies and other Providers of long-term care. While they do not "police" nursing homes and home health agencies, they work with the long-term care Provider and the Member, the Member's family or other representatives to resolve problems and concerns the Member or their representative may have about the quality of services received.

Ombudsmen link the Member with the services or agencies they need to live a more productive, fulfilling life. Ombudsmen advise the Member on selecting long-term care in Ohio, inform the Member about their rights and provide information, as well as assist with benefits and insurance.

To contact the Ombudsman for the specific region, please contact:

- **Region 1:** Cincinnati area serving – Butler, Clermont, Clinton, Hamilton and Warren counties
  Phone: (800) 488-6070
  Website: proseniors.org
- **Region 2:** Dayton area serving – Champaign, Clark, Darke, Greene, Logan, Miami, Montgomery, Preble and Shelby counties
  Phone: (800) 395-8267
  Website: dayton-ombudsman.org
- **Region 6:** Columbus area serving – Delaware, Fairfield, Franklin, Fayette, Licking, Madison, Pickaway and Union counties
  Phone: (800) 536-5891
  Website: centralohio.easterseals.com

Provider Claims Dispute (Adjustment Request)

For more information on Provider claims disputes, read the "Claim Reconsideration Request (Dispute)" section of this Provider Manual.

Molina's Right to Verify Waiver Services Rendered

Providers must follow the current Conditions of Participation and Service Specification requirements of the Medicaid Waiver(s) for which they are certified/approved. Each entity that pays claims will review the Provider's documentation to verify that services authorized and paid for are actually provided.

Incident and Provider Occurrences Reporting and Management

Molina participates in efforts to prevent, detect and remediate incidents and provider occurrences, based on requirements for home and community-based waiver programs.

It is important that our Providers report any activities that seem out of the norm. It is imperative that we ensure our Members are protected and safe from harm. Incidents and provider occurrences that occur in a Nursing Facility, inpatient behavioral health or home-and community-based service delivery setting (e.g., an adult day health care center, a Member's home or any other community-based setting), among other settings will be reported in a timely manner.

For additional information, review OAC 5160-44-05 Nursing facility-based level of care home, community-based services (HCBS) programs and specialized recovery services (SRS) program: incident management, or read the Reporting of Suspected Abuse and/or Neglect section under Health Care Services in this Provider Manual.

If you suspect neglect and/or abuse, please contact the waiver service coordinator and/or the appropriate authority dependent upon the nature of the incident.

Fighting Fraud, Waste and Abuse

Molina of Ohio maintains a comprehensive fraud, waste and abuse program.
For more information on fighting fraud, waste and abuse, read the Fraud, Waste and Abuse Program section of this Provider Manual.

Claims for MLTSS Services

Providers are required to bill Molina for all MLTSS waiver services through Electronic Data Interchange (EDI) submission or through the Provider Portal.

After registering on the Provider Portal, a Provider will be able to check eligibility, claim status and create/submit claims to Molina. To register please visit: Provider Portal.

For information on how to submit a claim via the Provider Portal contact the health plan Provider Services Team at (855) 322-4079.

Electronic Visit Verification (EVV)

ODM implemented Electronic Visit Verification (EVV) for some home and community-based services 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 home and community-based service 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 the date of the service, the time the service started and ended, the individual receiving the service, the person providing the service and the location of the service.

EVV applies to the following services:

- State Plan Home Health Aide
- State Plan Home Health Nursing
- State Plan RN Assessment
- HCBS 1915c Waiver Nursing
- HCBS 1915c Waiver Personal Care Aide
- HCBS 1915c Waiver Home Care Attendant
- Private Duty Nursing (PDN)

ODM has contracted with Sandata Technologies LLC to provide the Sandata EVV system at no cost to Providers or individuals receiving services. For additional information visit medicaid.ohio.gov and under "Initiatives" select "Electronic Visit Verification."

Upon future notice by ODM, Molina will begin denying Claims for Providers who do not utilize the EVV system.

Billing Molina

For more information on billing Molina, read the Claim Submission section of this Provider Manual.

Atypical Providers

Atypical Providers are service Providers that do not meet the definition of health care Provider. Examples include taxi services, home and vehicle modifications, insect control, habilitation and respite services, etc. Although they are not required to register for an NPI, these Providers perform services that are reimbursed by Molina.

Atypical Providers are required to use the Ohio Medicaid ID given to them by the State of Ohio to take the place of the NPI. As long as the Provider submits the Claim with the Medicaid ID number, the Claim will not be rejected back to the Provider for missing information.

NOTE: When billing Molina for MLTSS Services, the HCPC Code and Modifier Description Guide can be used to locate the proper billable codes. A numerical version of the guide is in the Appendix section of this manual.

Claims Submission: Provider Portal

We encourage our MLTSS Providers to utilize the Provider Portal to submit claims. Please see the Electronic Claim Submission section under Claims and Encounter Data in this Provider Manual. You may also contact your Provider Services Team for additional information at (855) 322-4079.

Timely Claim Filing

For more information on Timely Filing, read the Timely Claim Filing section under Claims and Compensation in this Provider Manual.

Timely Claim Processing

For more information on timely claim processing, read the Timely Claim Processing section under Claims and Compensation in this Provider Manual.

Billing Molina Members

Balanced Billing of a Medicaid recipient is prohibited by law. For more information on Billing Molina Members, read the Billing Molina Healthcare Members section under Claims and Compensation in this Provider Manual.

Patient Liability

For more information on Patient Liability, read the Patient Liability section under Claims and Compensation in this Provider Manual.

HCPC Code and Modifier Description

For additional information see the LTSS Waiver Billing Guidelines on our Provider Website, under the “Manual” tab, on the “Quick Reference Guides & FAQs” page.

Nursing Facility Billing Guidance

The Nursing Facility and Assisted Living Reference Guide for Ohio is available on the MyCare Ohio Molina Provider Website, under the Manual tab.

IX. Credentialing and Recredentialing

Note: Ohio Department of Medicaid's (ODM) centralized credentialing process is effective Oct. 1, 2022. Existing Molina Providers with recredentialing dates before Feb. 1, 2023, will complete Molina's recredentialing process. All recredentialing activities will transition to ODM on Feb. 1, 2023.

As of Oct. 1, 2022, ODM is responsible for credentialing all Medicaid and MyCare Ohio managed care Providers. The credentialing and recredentialing processes are paired with enrollment and revalidation, respectively, in the Provider Network Management system. This process adheres to National Committee for Quality Assurance (NCQA) and CMS federal guidelines for both processes and the types of Providers who are subject to the credentialing process.

Please note, you are not able to render services to Medicaid Members until you are fully screened, enrolled, and credentialed (if required) by Ohio Medicaid. For a complete list of provider types that require credentialing, please refer to Ohio Administrative Code (OAC) rule 5160-1-42.

For individual Providers, the general guidance is that licensed Providers who can practice independently under state law are required to go through this process. Medical students, residents, fellows, and Providers who practice strictly in an inpatient setting are exempt from credentialing. It is recommended that you begin the contracting process with each managed care organization (MCO) you wish to participate with while you are enrolling and being credentialed at ODM, in order to be able to render services as of your effective date. While the credentialing process is being centralized at the state Medicaid level, you are still required to contract with the MCOs. Providers will only be included in the MCO contract during the period credentialed or approved by ODM.

When you submit your initial application to be an Ohio Medicaid Provider, you can designate managed care organization interest in the PNM system. Once your application is submitted, demographic data for your Provider is transmitted automatically to the MCOs so they can start contracting with you.

Please direct any credentialing inquiries to the Ohio Department of Medicaid at Credentialing@medicaid.ohio.gov or visit the website: managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing.

Note: Existing Molina Providers with recredentialing dates before Feb. 1, 2023, will complete Molina's recredentialing process. All recredentialing activities will transition to ODM on Feb. 1, 2023.

X. Delegation

Delegation is a process that gives another entity the ability to perform specific functions on behalf of Molina. Molina may delegate:

1. Medical Management.
2. Credentialing and Recredentialing.
3. Sanction Monitoring for employees and contracted staff at all levels.
4. Claims.
5. Complex case management.
6. CMS Preclusion List Monitoring.
7. Other clinical and administrative functions.

When Molina delegates any clinical or administrative functions, Molina remains responsible to external regulatory agencies and other entities for the performance of the delegated activities, including functions that may be sub-delegated. To become a delegate, the Provider/Accountable Care Organization (ACO)/vendor must be in compliance with Molina's established delegation criteria and standards. Molina's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements. To remain a delegate, the Provider/ACO/vendor must maintain compliance with Molina's standards and best practices.

Delegation Reporting Requirements

Delegated entities contracted with Molina must submit monthly and quarterly reports. Such reports will be determined by the function(s) delegated and reviewed by Molina Delegation Oversight Staff for compliance with performance expectations within the timeline indicated by Molina.

Corrective Action Plans and Revocation of Delegated Activities

If it is determined that the delegate is out of compliance with Molina's guidelines or regulatory requirements, Molina may require the delegate to develop a corrective action plan designed to bring the delegate into compliance. Molina may also revoke delegated activities if it is determined that the delegate cannot achieve compliance or if Molina determines that is the best course of action.

If you have additional questions related to delegated functions, please contact your Molina Provider Services Team.

XI. Quality

A. Maintaining Quality Improvement Processes and Programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement Program. You can contact the Molina Quality Department toll free at (855) 322-4079.

The address for mail requests is:

Molina Healthcare of Ohio, Inc.
Quality Department
3000 Corporate Exchange Drive
Columbus, OH 43231

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

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

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

- Have a Quality Improvement Program in place.
- Comply with and participate in Molina's Quality Improvement Program including reporting of Access and Availability survey and activity results and provision of medical records as part of the HEDIS® review process and during potential quality of care and/or critical incident investigations.
- Cooperate with Molina's quality improvement activities that are designed to improve quality of care and services and Member experience.
- Allow Molina to collect, use and evaluate data related to Provider performance for quality improvement activities, including but not limited to focus areas, such as clinical care, care coordination and management, services, and access and availability.
- Allow access to Molina Quality personnel for site and medical record review processes.

B. Patient Safety Program

Molina's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Members in collaboration with their PCPs. Molina continues to support safe personal health practices for our Members through our Safety Program, Pharmaceutical Management and Care Management/Disease Management Programs and education. Molina monitors nationally recognized quality index ratings for facilities including adverse events and hospital acquired conditions as part of a national strategy to improve health care quality mandated by

the Patient Protection and Affordable Care Act (ACA), Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

MyCare Ohio: The Tax Relief and Health Care Act of 2006 mandates that the Office of Inspector General report to Congress regarding the incidence of "never events" among Medicare beneficiaries, the payment for services in connection with such events, and the Centers for Medicare & Medicaid Services (CMS) processes to identify events and deny payment.

C. Quality of Care

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

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

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

D. Medical Records

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

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

Medical Record Keeping Practices

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

- Each patient has a separate record
- Medical records are stored away from patient areas and preferably locked

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

Content

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

- Each page in the record contains the patient's name or ID number.
- Member name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact.
- Legible signatures and credentials of Provider and other staff members within a paper chart.
- All Providers who participate in the Member's care.
- Information about services delivered by these Providers.
- A problem list that describes the Member's medical and behavioral health conditions.
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Medication reconciliation within 30 days of the inpatient discharge should include evidence of current and discharge medication reconciliation and the date performed.
- Allergies and adverse reactions (or notation that none are known).
- Documentation that Advanced Directives, Power of Attorney and Living Will have been discussed with Member, and a copy of Advance Directives when in place.
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors.
- Treatment plans that are consistent with diagnosis.
- A working diagnosis that is recorded with the clinical findings.
- Pertinent history for the presenting problem.
- Pertinent physical exam for the presenting problem.
- Lab and other diagnostic tests that are ordered as appropriate by the Provider.

- Clear and thorough progress notes that state the intent for all ordered services and treatments.
- Notations regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed, included in the next preventative care visit when appropriate.
- Notes from consultants if applicable.
- Up-to-date immunization records and documentation of appropriate history.
- All staff and Provider notes are signed physically or electronically with either name or initials.
- All entries are dated.
- All abnormal lab/imaging results show explicit follow up plan(s).
- All ancillary services reports.
- Documentation of all emergency care provided in any setting.
- Documentation of all hospital admissions, inpatient and outpatient, including the hospital discharge summaries, hospital history and physicals and operative report.
- Labor and Delivery Record for any child seen since birth.
- A signed document stating with whom protected health information may be shared.

Organization

- The medical record is legible to someone other than the writer.
- Each patient has an individual record.
- Chart pages are bound, clipped, or attached to the file.
- Chart sections are easily recognized for retrieval of information.
- A release document for each Member authorizing Molina to release medical information for facilitation of medical care.

Retrieval

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

Confidentiality

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

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

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

E. Improving the Coordination and Continuity of Member Health Care

- Molina investigates and resolves all potential quality of care issues specific to coordination of care, involving appropriate practitioners and Providers as needed.
- A focused medical record audit for evidence of coordination of care is conducted annually, and deficient offices may receive a Corrective Action Plan (CAP) request based on this review. In order to ensure continuity and coordination of care, a follow-up review of medical records will be conducted for offices that have been issued CAPs.
- Molina conducts a Provider Satisfaction Survey including assessment of Providers' satisfaction with coordination of care between settings.
- Molina promotes enhanced communication between primary care Providers (PCPs) and specialty care practitioners by requiring specialty care practitioners to provide treatment notes to the PCP.
- Molina conducts the Consumer Assessment of Health Plan Survey (CAHPS®) to improve Member satisfaction.

F. Access to Care

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

and high impact specialists). Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on 90% availability for Emergency Services and 90% or greater for all other services. The PCP or their designee must be available 24 hours a day, 7 days a week to Members.

Appointment Access

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

Medical Appointment:Category	Type of Care	Access Standard
Child and Adolescent Needs and Strengths (CANS)	Assessment for the purpose of determining OhioRISE eligibility	Initial CANS assessment for OhioRISE eligibility must be scheduled within 72 hours of referral.
		CANS assessment must be completed within 10 business days after scheduling. If it's in the best interest of the Member to allow for more than 10 business days to complete the CANS, Molina shall assist in facilitating the assessment as expeditiously as possible.
Mobile Response and Stabilization Service (MRSS)	Crisis Mobile Response	Initial response within 60 minutes from the time of dispatch, or within 48 hours timeframe if the caller requests a mobile response later than 60 minutes.
	Follow-Up Services	Conduct Brief CANS assessment during 72 hour period of mobile response de-escalation services.
	Stabilization Services	Notification to Molina at OHBehavioralHealthReferrals@Molinahealthcare.com within three business days of initiation, termination, and transition of stabilization services
Primary Care Physicians (PCPs)*:	Emergency needs	Immediately upon presentation.
	Urgent care	No later than the end of the following business day after the patent's initial contact with the PCP site.
	Regular and routine care	Not to exceed six weeks.

OB/GYN	Pregnancy (initial visit)	Within two weeks.
	Routine visit	Within six weeks.
Oncology	Emergency needs	Immediately upon presentation.
	Urgent care	Not to exceed 24 hours.
	Regular and routine care	Within six weeks.
Non-PCP Specialist	Emergency needs	Immediately upon presentation.
	Urgent care	Not to exceed 24 hours.
	Regular and routine care	Within eight weeks.

*Ohio Comprehensive Care Program (CPC) Access to Care Standards – Ohio CPC practices should consult their contractual agreements for additional requirements.

Behavioral Health Appointments:

Category	Type of Care	Access Standard
Behavioral Health Specialists	Emergency needs	Immediately upon presentation
	Non-life-threatening emergency	Not to exceed six hours
	Urgent care	Not to exceed 48 hours
	Initial visit for routine care	Not to exceed 10 business days
	Follow-up routine care	Not to exceed 10 calendar days based off the condition

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

Office Wait Time

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

After Hours

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a 24-hour telephone service, 7 days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an emergency to hang up and call 911 or go immediately to the nearest emergency room. Voicemail alone after-hours is not acceptable.

G. Member's Obstetric and Gynecological Health Access

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

Ohio regulations require that a Member be permitted direct access to contracted obstetric and gynecological health care Providers without a referral or prior authorization. Member's obstetric and gynecological health services must be obtained from a Molina network Provider or a Qualified Family Planning Provider (QFPP). Members may seek direct care from any participating obstetric and gynecological health care Provider or QFPP for any of the following types of service:

- Maternity
- Gynecological
- Preventive care
- Other health problems discovered and treated during the course of the visit which are within the Provider's scope of practice

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

H. Monitoring Access for Compliance with Standards

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

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

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

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

I. Quality of Provider Office Sites

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

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

Physical Accessibility

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

Physical Appearance

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

Adequacy of Waiting and Examining Room Space

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

Administration and Confidentiality of Facilities

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

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted, and parking area and walkways demonstrate appropriate maintenance.
- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two office exam rooms per Provider.
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one CPR certified employee is available.
- Yearly OSHA training (Fire, Safety, Bloodborne Pathogens, etc.) is documented for offices with 10 or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, and contracts evidence of a hazardous waste management system in place.
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A CLIA waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double-locked. Medication and sample Access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

J. Advance Directives (Patient Self-Determination Act)

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

Advance Directives are a written choice for health care. There are four types of Advance Directives in Ohio:

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

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

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

New adult Members or their identified personal representative will receive educational information and instructions on how to access advance directives forms in their Member Handbook, and other Member communications such as newsletters and the Molina website. If a Member is incapacitated at the time of enrollment, Molina will provide advance directive information to the Member's family or representative and will follow up with information to the Member at the appropriate time. All current Members will receive annual notice explaining this information, in addition to newsletter information.

Members who would like more information are instructed to contact Member Services or visit Midwest Care Alliance's website at: midwestcarealliance.org as a resource and to access forms for download. Additionally, the Molina website offers information to both Providers and Members regarding Advance Directives, with a link to forms that can be downloaded and printed.

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

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

In no event may any Provider refuse to treat a Member or otherwise discriminate against a Member because the Member has completed an Advance Directive. CMS law gives Members the right to file a complaint with Molina or the state survey and certification agency if the

Member is dissatisfied with Molina's handling of Advance Directives and/or if a Provider fails to comply with Advance Directives instructions.

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. Under Ohio law, patients have the right to file a complaint related to Advance Directives with the Ohio Department of Health.

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

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

K. EPSDT Services to Enrollees Under 21 Years of Age

Molina maintains systematic and robust monitoring mechanisms to ensure all required Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to enrollees under 21 years of age are timely according to required preventive guidelines. All enrollees under 21 years of age should receive preventive, diagnostic and treatment services at intervals as set forth in Section 1905(R) of the Social Security Act. Molina's Quality or Provider Services Department is also available to perform Provider training to ensure that best practice guidelines are followed in relation to well child services and care for acute and chronic health care needs.

L. Well Child/Adolescent Visits

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

- Comprehensive health and developmental history.
- Nutritional assessment.
- Height and weight and growth charting.
- Comprehensive unclothed physical examination.
- Appropriate immunizations according to the Advisory Committee on Immunization Practices.
- Laboratory procedures, including lead blood level assessment appropriate for age and risk factors.
- Periodic developmental and behavioral screening using a recognized, standardized developmental screening tool.
- Vision and hearing tests.
- Dental assessment and services.
- Risk assessment.

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

Diagnostic services, treatment, or services Medically Necessary to correct or ameliorate defects, physical or mental illnesses, and conditions discovered during a screening or testing must be provided or arranged for either directly or through referrals.

Any condition discovered during the screening examination or screening test requiring further diagnostic study or treatment must be provided if within the Member's Covered Benefit services. Members should be referred to an appropriate source of care for any required services that are not Covered Services.

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

M. Monitoring for Compliance with Standards

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

N. Quality Improvement Activities and Programs

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

O. Health Management and Care Management

The Molina Health Management and Care Management Programs provide for the identification, assessment, stratification, and implementation of appropriate interventions for Members with chronic diseases.

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

P. Clinical Practice Guidelines

Molina adopts and disseminates Clinical Practice Guidelines (CPGs) to reduce inter- Provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriately established authority. Clinical Practice Guidelines are reviewed at least annually and more frequently as needed, when clinical evidence changes and approved by the Quality Improvement Committee.

Molina Clinical Practice Guidelines include the following:

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

The adopted CPGs are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates and Members by the Quality, Provider Services, Health Education and Member Services Departments. The guidelines are disseminated through Provider Newsletters, electronic Provider Bulletins and other media, and are available on the Molina website. Individual Providers or Members may request copies from the local Molina Quality Department.

Q. Preventive Health Guidelines

Molina provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF), Bright Futures/American

Academy of Pediatrics and Centers for Disease Control and Prevention (CDC), in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include, but are not limited to:

- Recommendations for Preventive Pediatric Health Care
- Recommended Adult Immunization Schedule for ages 19 Years or Older, United States, 2021
- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2021

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

R. Cultural and Linguistic Services

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

S. Measurement of Clinical and Service Quality

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

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

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

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

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

T. Healthcare Effectiveness Data and Information Set (HEDIS®)

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

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

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

U. Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

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

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

V. Behavioral Health Satisfaction Assessment

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

W. Medicare Health Outcomes Survey (HOS)

The HOS measures Medicare Members' physical and mental health status over a two year period and categorizes the two year change scores as better, same or worse than expected. The goal of the HOS is to gather valid, reliable, clinically meaningful data that can be used to target quality improvement activities and resources, monitor health plan performance and reward top performing health plans. Additionally, the HOS is used to inform beneficiaries of their health care choices, advance the science of functional health outcomes measurement, and for quality improvement interventions and strategies.

X. Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS®/Qualified Health plan Enrollee Experience Survey both focus on Member experience with health care Providers and health plans, Molina conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina, as this is one of the primary methods used to identify improvement areas pertaining to the Molina Provider network. The survey results have helped establish improvement activities relating to Molina's specialty network, inter-Provider communications and pharmacy authorizations. This survey is fielded to a random sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Y. Effectiveness of Quality Improvement Initiatives

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

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

Z. What Can Providers Do?

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

Molina has additional resources to assist Providers and their patients. For access to tools that can assist, please visit the Provider Portal. There are a variety of resources, including HEDIS®

CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and CAHPS® Star Ratings measures, contact your local Molina Quality Department.

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

AA. MyCare Ohio Medicare Merit-Based Incentive Payment System (MIPS)

Under the Medicare Access and CHIP Reauthorization Act (MACRA), CMS implemented the Quality Payment Program Merit-based Incentive Payment System (MIPS). This is a quality payment program that eligible Providers under original Medicare will participate in and does not impact how Medicare Advantage and MMP plans are required to pay. Due to this being a quality program, Providers will not receive a bonus or a withhold for the Quality Payment Program Merit-based Incentive Payment System (MIPS), unless it is specifically in the agreement you have with Molina. Please contact your Provider Services Team for other quality programs Molina offers.

XII. Cultural Competency and Linguistic Services

A. Background

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency (LEP) and Members who are deaf, hard of hearing, non-verbal, have a speech impairment, or have an intellectual disability. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, genders, gender 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.

Additional information on cultural competency and linguistic services is available at MolinaHealthcare.com/OhioProviders, from your local Provider Services Team and by calling Molina Provider Services at (855) 322-4079.

B. Nondiscrimination of Health Care Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act (ACA), which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina website homepages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina requires Providers to deliver services to Molina Members without regard to age, race, creed, color, genetic information, national origin, ancestry, sex, sexual orientation, gender identity, sex stereotyping, marital status, pregnancy, military status, religion, physical, mental or sensory disability, place of residence, health status, socioeconomic status, status as a recipient of Medicaid benefits, or need for health services. Providers must post a non-discrimination notification in a conspicuous location in their office along with translated non-English taglines in the top languages spoken in the state to ensure Molina Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred. For additional information, please refer to the Member Handbook located at MolinaHealthcare.com.

Additionally, participating Providers or contracted Medical Groups/Independent Physician Associations (IPAs) may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.

Providers can refer Molina Members who are complaining of discrimination to the Molina Civil Rights Coordinator at: (866) 606-3889, or TTY/TDD 711.

Members can also email the complaint to civil.rights@MolinaHealthcare.com.

Members can mail their complaint to Molina at:
Molina Healthcare, Inc.
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802

Members can also file a civil rights complaint with the U.S. Department of Health and Human Services, OCR. Complaint forms are available at hhs.gov/ocr/complaints/index.html. The form can be mailed to:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Members can also send it to a website through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf.

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

Should you or a Molina Member need more information, refer to the Health and Human Services website: federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority

C. Cultural Competency

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

D. Provider and Community Training

Molina offers educational opportunities in cultural competency concepts for Providers, their staff, and Community Based Organizations (CBO). Molina conducts Provider training during Provider orientation with annual reinforcement training offered through Provider Services and/or online/Web-based training modules.

Training modules, delivered through a variety of methods, include:
1. Provider written communications and resource materials.
2. Online cultural competency Provider training modules.
3. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications.

E. Integrated Quality Improvement – Ensuring Access

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

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

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

F. Program and Policy Review Guidelines

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

- Annual collection and analysis of race, ethnicity and language data from:
  - Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's membership.
  - Contracted Providers to assess gaps in network demographics.
- Local geographic population demographics and trends derived from publicly available sources (Community Health Measures and State Rankings Report).
- Applicable national demographics and trends derived from publicly available sources
- Assessment of Provider Network.
- Collection of data and reporting for the Diversity of Membership HEDIS® measure.
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations.
- Analysis of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

G. Access to Interpreter Services

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

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

An LEP individual has a limited ability or inability to read, speak or write English well enough to understand and communicate effectively (whether because of language, cognitive or physical limitations).

Molina Members are entitled to:

- Be provided with effective communications with medical Providers as established by the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and the Civil Rights Act of 1964.
- Be given access to Care Managers trained to work with cognitively impaired individuals.
- Be notified by the medical Provider that interpreter services are available at no cost.

- Decide, with the medical Provider, to use an interpreter and receive unbiased interpretation.
- Be assured of confidentiality, as follows:
  - Interpreters must adhere to Health and Human Service Commission (HHSC) policies and procedures regarding confidentiality of Member records.
  - Interpreters may, with Member written consent, share information from the Member's records only with appropriate medical professionals and agencies working on the Member's behalf.
  - Interpreters must ensure that this shared information is similarly safeguarded.
- Have interpreters, if needed, during appointments with the Member's Providers and when talking to the health plan.

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

When Molina Members need an interpreter, limited hearing and/or limited reading services for health care services, the Provider should:

- Verify the Member's eligibility and medical benefits.
- Inform the Member that an interpreter, limited hearing and/or limited reading services are available.
- Molina is available to assist Providers with locating these services if needed:
  - Providers needing assistance finding on-site interpreter services may call Molina Member Services.
  - Providers needing assistance finding translation services may call Molina Member Services.
  - Providers with Members who cannot hear or have limited hearing ability may use the Ohio Relay service (TTY) at 711.
  - Providers with Members with limited vision may contact Molina Member Services for documents in large print, Braille or audio version.
  - Providers with Members with limited reading proficiency (LRP) may contact Molina Member Services.
    - The Molina Member Service Representative will verbally explain the information, up to and including reading the documentation to the Members or offer the documents in audio version
  - Contact Molina Member Services at:
    - Medicaid: (800) 642-4168 (TTY/Ohio Relay (800) 750-0750 or 711), Monday through Friday from 7 a.m. to 7 p.m.
    - Molina MyCare Ohio Dual Options Medicare-Medicaid Plan: (855) 665-4623 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.
    - Molina MyCare Ohio Medicaid Only: (855) 687-7862 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.

Molina asks Providers to inform Molina when providing interpreter services to Molina Members. Providers may report this information to Molina by calling Molina Member Services.

H. Documentation

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

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

I. Members Who Are Deaf or Hard of Hearing

Molina provides a TTY/TDD connection, accessible by dialing 711. This connection provides access to Member & Provider Contact Center, Quality, Healthcare Services and all other health plan functions.

Molina strongly recommends that Provider offices make an ASL interpreter available for face-to-face service delivery or make assistive listening devices available for Members who are deaf and hard of hearing. Assistive listening devices enhance the sound of the Provider's voice to facilitate a better interaction with the Member.

Nurse Advice Line

Molina provides Nurse Advice services for Members 24 hours per day, 7 days a week. The Nurse Advice Line provides access to 24-hour interpretive services. Members may call Molina's Nurse Advice Line directly. The Medicaid English line at (888) 275-8750, Spanish line at (866) 648-3537 or TTY/TDD is 711, and at (855) 895-9986 for MyCare Ohio. The Nurse Advice Line telephone numbers are also printed on membership cards.

XIII. Compliance

A. Fraud, Waste, and Abuse

Introduction

Molina is dedicated to the detection, prevention, investigation and reporting of potential health care fraud, waste, and abuse. As such, Molina's Compliance Department maintains a comprehensive plan, which addresses how Molina will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. The plan also addresses fraud,

waste and abuse prevention and detection along with the education of appropriate employees, vendors, Providers and associates doing business with Molina.

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

Mission Statement

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

Regulatory Requirements

- **Federal False Claims Act**

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

  The term "knowing" is defined to mean that a person with respect to information:
  - Has actual knowledge of falsity of information in the Claim;
  - Acts in deliberate ignorance of the truth or falsity of the information in a Claim; or,
  - Acts in reckless disregard of the truth or falsity of the information in a Claim.

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

- **Deficit Reduction Act**

  The Deficit Reduction Act (DRA) aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

  As a contractor doing business with Molina, Providers and their staff have the same obligation to report any actual or suspected violation fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:
  - The Federal False Claims Act and state laws pertaining to submitting false Claims

- How Providers will detect and prevent fraud, waste, and abuse
- Employee protection rights as whistleblowers

These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims Act. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

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

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

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

- **Anti-Kickback Statute** – Provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable or reimbursable under the Medicare or other federal health care programs.

- **Stark Statute** – Similar to the Anti-Kickback Statute, but more narrowly defined and applied. It applies specifically to services provided only by Practitioners, rather than by all health care Providers.

- **Sarbanes-Oxley Act of 2002** – Requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Definitions

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

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

Abuse: means Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary costs to state and federal health care programs, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to state and federal health care programs. (42 CFR § 455.2)

Examples of Fraud, Waste and Abuse by a Provider

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

- A Provider knowingly and willfully referring a Member to health care facilities in which or with which the Provider has a financial relationship.
- Altering Claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a Molina Member for Covered Services. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.
- Billing and providing for services to Members that are not Medically Necessary.
- Billing for services, procedures and/or supplies that have not been rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.
- Completing certificates of Medical Necessity for Members not personally and professionally known by the Provider.
- Concealing a Member's misuse of a Molina identification card.
- Failing to report a Member's forgery or alteration of a prescription or other medical document.
- False coding in order to receive or maximize reimbursement.
- Inappropriate billing of modifiers in order to receive or maximize reimbursement.
- Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement.
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients.
- Not following incident to billing guidelines in order to receive or maximize reimbursement.
- Overutilization.
- Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges.

- Questionable prescribing practices.
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are Medically Necessary.
- Upcoding, which is when a Provider does not bill the correct code for the service rendered, and instead uses a code for a like services that costs more.
- Using the adjustment payment process to generate fraudulent payments.

Examples of Fraud, Waste, and Abuse by a Member

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

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

Review of Provider Claims and Claims System

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

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

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

Prepayment Fraud, Waste, and Abuse Detection Activities

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

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

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

Post-payment Recovery Activities

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

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

Provider will provide Molina, governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Molina, in Molina's sole discretion, necessary to determine compliance with the terms of the Provider Agreement, including for the purpose of investigating potential fraud, waste and abuse. Documents and records must be readily accessible at the location where Provider provides services to any Molina Members. Auditable documents and records include, but are not limited to, medical charts; patient charts; billing records; and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by Molina and without charge to Molina. In the event Molina identifies fraud, waste or abuse, Provider agrees to repay funds or Molina may seek recoupment.

If a Molina auditor is denied access to Provider's records, all of the Claims for which Provider received payment from Molina is immediately due and owing. If Provider fails to provide all requested documentation for any Claim, the entire amount of the paid Claim is immediately due and owing. Molina may offset such amounts against any amounts owed by Molina to

Provider. Provider must comply with all requests for documentation and records timely (as reasonably requested by Molina) and without charge to Molina. Claims for which Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

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

B. Claim Auditing

Molina shall use established industry Claims adjudication and/or clinical practices, state, and federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding, and payment.

Provider acknowledges Molina's right to conduct pre and post-payment billing audits. Provider shall cooperate with Molina's Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon Molina's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

In reviewing medical records for a procedure, Molina may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims that Molina paid in error. The estimated proportion, or error rate, may be projected across all Claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal Claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor assisted. Molina asks that you provide Molina, or Molina's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If Molina's Special Investigations Unit suspects that there is fraudulent or abusive activity, Molina may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

Provider Education

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

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

Reporting Fraud, Waste, and Abuse

If you suspect cases of fraud, waste or abuse, you must report it by contacting the Molina AlertLine. AlertLine is an external telephone and web-based reporting system hosted by NAVEX Global, a leading Provider of compliance and ethics hotline services. AlertLine telephone and web-based reporting is available 24 hours a day, 7 days a week, 365 days a year.

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

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

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

Molina Healthcare of Ohio
Attn: Compliance
P.O. Box 349020
3000 Corporate Exchange Drive
Columbus, OH 43234

Remember to include the following information when reporting:

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

Medicaid Fraud, Waste, and Abuse:

Suspected fraud, waste and abuse may also be reported directly to the state. If you suspect that a Medicaid recipient has committed fraud or abuse and would like to report it, please contact the County Department of Job and Family Services (CDJFS) in which the beneficiary resides. The number can be found in the CDJFS directory at jfs.ohio.gov/county/ county_directory.pdf or in the telephone book under "County Government." If you are unable to locate the number, please call the Ohio Department of Job and Family Services General Information Customer Service number at (877) 852-0010 for assistance.

Additional reporting may be made to the following state entities:

Ohio Department of Medicaid (ODM) (614) 466-0722 or at https://medicaid.ohio.gov/wps/portal/gov/medicaid/stakeholders-and-partners/helpfullinks/reporting-suspected-medicaid-fraud

Office of the Ohio Attorney General, Medicaid Fraud Control Unit (MFCU) (800) 642-2873 or at https://medicaid.ohio.gov/wps/portal/gov/medicaid/stakeholders-and-partners/helpfullinks/reporting-suspected-medicaid-fraud ohioattorneygeneral.gov/Individuals-and-Families/Victims/Submit-a-Tip/Report-Medicaid-Fraud

Ohio Department of Job and Family Services (614) 752-3222 or at jfs.ohio.gov/fraud/index.stm

The Ohio Auditor of State (AOS) (866) FRAUD-OH or by email at fraudohio@ohioauditor.gov

If you suspect a Provider to have committed fraud or abuse of the Medicaid program, or have specific knowledge of corrupt or deceptive practices by a Provider, you should contact the Ohio Attorney General's Medicaid Fraud Control Unit at (614) 466-0722 or the Attorney General's Help Center at (800) 282-0515.

MyCare Ohio Fraud, Waste, and Abuse:

CMS Toll Free Phone: 1-800-MEDICARE (1-800-633-4227), or

Office of Inspector General
Attn: OIG Hotline Operations
PO Box 23489
Washington, DC 20026

Toll Free Phone: (800) 447-8477
TTY/TDD: (800) 377-4950
Fax (10 page max): (800) 223-8164

Online at the Health and Human Services Office of the Inspector General Website: oig.hhs.gov/FRAUD/REPORT-FRAUD/INDEX.ASP

C. HIPAA Requirements and Information

HIPAA (Health Insurance Portability and Accountability Act)

Molina's Commitment to Patient Privacy

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

To view our Notice of Privacy Practices for our Medicaid Members, please visit our Member website at MolinaHealthcare.com/Members and select "HIPAA Privacy Notice" at the bottom of the page.

Provider Responsibilities

Molina expects that its 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 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 PHI and includes a summary of how Molina safeguards 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).

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 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.

Use and Disclosure of PHI

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

Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[1]. Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services[2]."
2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:
   - Quality Improvement
   - Disease Management
   - Care Management and Care Coordination
   - Training Programs
   - Accreditation, Licensing and Credentialing

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

Confidentiality of Substance Use Disorder Patient Records

[1] See, Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.
[2] See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

Federal Confidentiality of Substance Use Disorder Patients Records regulations apply to any entity or individual providing federally-assisted alcohol or drug abuse prevention or treatment. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with substance use disorder treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, the Federal Confidentiality of Substance Use Disorder Patients Records regulations are more restrictive than HIPAA and they do not allow disclosure without the Member's written consent except as set forth in 42 CFR Part 2.

Inadvertent Disclosures of PHI

Molina may, on occasion, inadvertently misdirect or disclose PHI pertaining to Molina Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected Molina Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI and further agrees to provide an attestation of return, destruction and non-disclosure of any such misdirected PHI upon the reasonable request of Molina.

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable state law.

Patient Rights

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

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

2. **Requests for Restrictions on Uses and Disclosures of PHI**
   Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.

3. **Requests for Confidential Communications**
   Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.

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

5. **Request to Amend PHI**
   Patients have a right to request that the Provider amend information in their designated record set.

6. **Request Accounting of PHI Disclosures**
   Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six-year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations or made prior to April 14, 2003.

HIPAA Security

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

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

HIPAA Transactions and Code Sets

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

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

- Remittance advices

Molina is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to Molina's website at MolinaHealthcare.com/OhioProviders for additional information regarding HIPAA standard transactions.

1. Click on the area titled "Health Care Professionals"
2. Click the tab titled "HIPAA"
3. Click on the tab titled "HIPAA Transaction" or "HIPAA Code Sets"

Code Sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions.

National Provider Identifier (NPI)

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

Additional Requirements for Delegated Providers

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

Reimbursement for Copies of PHI

Molina does not reimburse Providers for copies of PHI related to our Members. These requests may include, although are not limited to, the following purposes:

- Utilization Management.
- Care Coordination and/or Complex Medical Care Management Services.
- Claims Review.
- Resolution of an Appeal and/or Grievance.
- Anti-Fraud Program Review.
- Quality of Care Issues.

- Regulatory Audits.
- Risk Adjustment.
- Treatment, Payment and/or Operation Purposes.
- Collection of HEDIS® medical records.

Categories of Permitted Uses & Disclosures of PHI

- **Treatment (T):**
  - Referrals
  - Provision of care by Providers
- **Payment (P):**
  1. Eligibility verification
  2. Enrollment/disenrollment
  3. Claims processing and payment
  4. Coordination of benefits
  5. Subrogation
  6. Third party liability
  7. Encounter data
  8. Member utilization management (UM)/Claims correspondence
  9. Capitation payment and processing
  10. Collection of premiums or reimbursements
  11. Drug rebates
  12. Reinsurance Claims
  13. UM:
      - Pre-authorizations
      - Concurrent reviews
      - Retrospective reviews
      - Medical Necessity reviews
- **Health Care Operations (HCO):**
  1. Quality assessment and improvement:
      - Member satisfaction surveys
      - Populated based Quality Improvement (QI) studies
      - HEDIS® measures
      - Development of clinical guidelines
      - Health improvement activities
      - Care management contacting Providers and Members about treatment alternatives
      - Disease management
  2. Credentialing and accreditation:
      - Licensing
      - Provider credentialing
      - Accreditation (e.g., NCQA)
      - Evaluating Provider or practitioner performance

3. Underwriting or contract renewal
4. Auditing – conducting or arranging for:
    - Auditing
    - Compliance
    - Legal
    - Fraud and abuse detection
    - Medical review
5. Business planning and development:
    - Cost management
    - Budgeting
    - Formulary development
    - Mergers and acquisitions, including due diligence
6. Business management and general administrative activities:
    - Member Services, including complaints and grievances, and Member materials fulfillment
    - De-identification of data
    - Records and document management (if the documents contain PHI)

Other Permitted Uses and Disclosures (OP):

1. Public Health:
    - Reporting to immunization registries
    - Reporting of disease and vital events
    - Reporting of child abuse or neglect
    - Report adverse events for FDA-regulated products
    - Victims of abuse, neglect or domestic violence (except for child abuse) to regulators (e.g., Ohio Department of Insurance) for Health Care Oversite, including audits, civil and criminal investigations
2. Judicial and administrative proceedings:
    - Court orders
    - Subpoenas and discovery requests (without court order)
    - Workers' compensation
3. Disclosures for law enforcement:
    - Court ordered warrants and summons
    - Grand jury subpoenas
    - Identification and location purposes
4. Information about decedents:
    - To coroners and medical examiners
    - To funeral directors
    - Organ donation
5. Research (e.g., clinical trials)
6. Special government functions:
    - Military activities

- National security
- Protective services for President

Business Continuity Plan (BCP)

The Provider will have a documented Business Continuity Plan (BCP) to ensure continuation and recovery of services after a Disaster Declaration occurs. The BCP will be updated at least annually and approved by the applicable designated representative.

The Provider Business Continuity Plan will include:

- Names and contact information for staff responsible for invoking and managing response and recovery
- Disaster Declaration process
- Details of how the services will be recovered and restored
- Disaster Recovery Plan which includes details of how the systems and applications supporting the services will be recovered and restored, including recovery of data

The Provider will notify Molina Provider Services with regular updates on the situation and actions taken to resolve the issue, until normal services have been resumed.

The Provider will ensure that its third parties needed to deliver the services have appropriate Business Continuity Plans in place to prevent significant disruption to the services.

The Provider will test the BCP at least annually and document the test results. Provider will make available to Molina, upon request, the results of the most recent test including lessons learned and remediation plans.

The Provider will participate in Molina annual tests upon notification and mutual agreement.

Definitions

Business Continuity Plan: documented procedures that guide organizations to respond, recover, resume and restore to a pre-defined level of operations following a disaster.

Disaster Recovery Plan: a document that defines the resources, actions, tasks and data required to manage the technology recovery effort.

Disaster Declaration: criteria to declare a disaster and the staff authorized to invoke recovery plans to recover and restore Services.

Cybersecurity Requirements

Note: This section (Cybersecurity Requirements) is only applicable to providers who are delegated providers and have been delegated by Molina to perform a health plan function.

1. Provider shall comply with the following requirements and permit Molina to audit such compliance as required by law or any enforcement agency.
2. The following terms are defined as follows:
   I. "Consumer" means an individual who is a State resident, whose Nonpublic Information is in Molina's possession, custody or control and which Provider maintains, processes, stores or otherwise has access to such Nonpublic Information.
   II. "Cybersecurity Event" means any act or attempt, successful or, to the extent known by Provider, unsuccessful, to gain unauthorized access to, disrupt or misuse an Information System or Nonpublic Information stored on such Information System. The ongoing existence and occurrence of attempted but Unsuccessful Security Incidents shall not constitute a Cybersecurity Event under this definition. "Unsuccessful Security Incidents" are activities such as pings and other broadcast attacks on Provider's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of Molina Nonpublic Information or sustained interruption of service obligations to Molina.
   III. "Information System" or "Information Systems" means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination or disposition of electronic Nonpublic Information, as well as any specialized system such as industrial or process controls systems, telephone switching and private branch exchange systems, and environmental control systems.
   IV. "Nonpublic Information" means information that is not publicly available information and is one of the following:
      (a) business related information of Molina the tampering with which, or unauthorized disclosure, access, or use of which, would cause a material adverse impact to the business, operations, or security of Molina;
      (b) any information concerning a Consumer that because of the name, number, personal mark, or other identifier contained in the information can be used to identify such Consumer, in combination with any one or more of the following data elements:
         (i) social security number;
         (ii) driver's license number, commercial driver's license or state identification card number;
         (iii) account number, credit or debit card number;
         (iv) security code, access code, or password that would permit access to a Consumer's financial account; or
         (v) biometric records;
      (c) any information or data, except age or gender, in any form or medium created by or derived from a health care provider or a Consumer, that can be used to identify a particular Consumer, and that relates to any of the following:
         (i) the past, present, or future physical, mental or behavioral health or condition of a Consumer or a member of the Consumer's family;
         (ii) the provision of health care to a Consumer; or
         (iii) payment for the provision of health care to a Consumer.

V. "State" means the State of Ohio.

3. Provider shall implement appropriate administrative, technical, and physical measures to protect and secure the Information Systems and Nonpublic Information, as defined herein, that are accessible to, or held by, the Provider. Implementation of the foregoing measures shall incorporate guidance issued by the State Department of Insurance, as appropriate.
4. Provider agrees to comply with all applicable laws governing Cybersecurity Events. Molina will decide on notification to affected Consumers or government entities. Upon Molina's prior written request, Provider agrees to assume responsibility for informing all such Consumers in accordance with applicable law.
5. In the event of a Cybersecurity Event, Provider shall notify Molina's Chief Information Security Officer of such Cybersecurity Event by telephone and email (as provided below) as promptly as possible, but in no event later than seventy-two (72) hours from a determination that a Cybersecurity Event has occurred. A follow-up notification shall be provided by mail, at the address indicated below.

   Notification to Molina's Chief Information Security Officer shall be provided to:

   Molina Chief Information Security Officer
   Telephone: 844-821-1942
   Email: CyberIncidentReporting@MolinaHealthcare.com

   Molina Chief Information Security Officer
   Molina Healthcare, Inc.
   200 Oceangate Blvd., Suite 100
   Long Beach, CA 90802

6. Upon Provider's notification to Molina of a determination of a Cybersecurity Event, Provider must promptly provide Molina any documentation required and requested by Molina to complete an investigation, or, upon written request by Molina, Provider shall complete an investigation pursuant to the following requirements:
   (a) determine whether a Cybersecurity Event occurred;
   (b) assess the nature and scope of the Cybersecurity Event;
   (c) identify Nonpublic Information that may have been involved in the Cybersecurity Event; an
   (d) perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release, or use of the Nonpublic Information.
7. Provider shall maintain records concerning all Cybersecurity Events for a period of at least five (5) years from the date of the Cybersecurity Event or such longer period as required by applicable laws and produce those records upon request of Molina.
8. Provider must provide to Molina the documentation required and requested by Molina in electronic form. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Molina concerning the Cybersecurity Event. The information provided to Molina in the initial and subsequent notices must include as much of following information known to Provider at the time of the notification:

(a) the date of the Cybersecurity Event;
(b) a description of how the information was exposed, lost, stolen, or breached, including the specific roles and responsibilities of Provider, if any;
(c) how the Cybersecurity Event was discovered;
(d) whether any lost, stolen, or breached information has been recovered and if so, how this was done;
(e) the identity of the source of the Cybersecurity Event;
(f) whether Provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and, if so, when such notification was provided;
(g) a description of the specific types of information acquired without authorization, which means particular data elements including, for example, types of medical information, types of financial information, or types of information allowing identification of the Consumer;
(h) the period during which the Information System was compromised by the Cybersecurity Event;
(i) the number of total Consumers in the State affected by the Cybersecurity Event;
(j) the results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;
(k) a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;
(l) a copy of Provider's privacy policy and if requested by Molina, the steps that Provider will take to notify Consumers affected by the Cybersecurity Event; and
(m) the name of a contact person who is both familiar with the Cybersecurity Event and authorized to act on behalf of Provider.

In the event provisions of this Section conflict with provisions of any other agreement between Molina and Provider, the stricter of the conflicting provisions will control.

XIV. Members' Rights and Responsibilities

Providers must cooperate with the rights and responsibilities of Molina Members as outlined in the Molina Member Handbook and on the Molina website. The Member Handbook is provided to Members annually and is hereby incorporated into this Provider Manual. The most current Member Rights and Responsibilities can be accessed via the following link:

- Medicaid: Member Handbook
- MyCare Ohio: Member Handbook

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

For additional information, please contact Molina at (855) 322-4079, Monday through Friday from 8 a.m. to 6 p.m. for Molina Dual Options MyCare Ohio or 8 a.m. to 5 p.m. for all other lines of business. TTY users, please call 711.

Second Opinions

If Members do not agree with their Providers' plan of care, they have the right to a second opinion from another Provider. Members should call Member Services to find out how to get a second opinion. Second opinions may require prior authorization.

A. Open Access Health Care Services

Members must receive services covered by Molina from facilities and/or Providers on Molina's panel. Members may use Providers that are not on Molina's panel for the following services:

- Federally qualified health centers/rural health clinics
- Qualified family planning Providers
- Community mental health centers
- Ohio Department of Mental Health and Addiction Services (ODMHAS) facilities which are Medicaid Providers
- Emergency Services
- Services prior authorized by Molina

In addition, Molina Dual Options Members have the right to:

- Request a State Fair Hearing by calling (800) 952-5253. Members also have the right to receive information on the reason for which an expedited State Fair Hearing is possible.
- Receive family planning services, treatment for any sexually transmitted disease and emergency care services from Federally Qualified Health Centers without receiving prior approval and authorization from Molina.

XV. Appeals and Grievances

Appeals, Grievances and State Hearings

Molina maintains an organized and thorough grievance and appeal process to ensure timely, fair, unbiased, and appropriate resolutions. Molina Members, or their authorized representatives, have the right to voice a grievance or submit an appeal through a formal process.

Molina ensures that Members have access to the appeal process, by providing assistance throughout the whole procedure in a culturally and linguistically appropriate manner; including oral, written, and language assistance if needed. Grievance information is also included in the Member Handbook.

This section addresses the identification, review, and resolution of Member grievances and appeals.

Definitions

The Ohio Administrative Code defines a grievance (complaint) as an expression of dissatisfaction with any aspect of Molina or participating Providers' operations, provision of health care services, activities or behaviors.

An appeal is the request for a review of an adverse benefit determination. The Member or their representative acting on the Member's behalf has the right to appeal Molina's decision to deny a service.

Member Grievances

Members may file a grievance by calling Molina's Member Services Department at:

- Medicaid: (800) 642-4168 (TTY/Ohio Relay (800) 750-0750 or 711), Monday through Friday from 7 a.m. to 7 p.m.
- Molina Dual Options MyCare Ohio Medicare-Medicaid Plan: (855) 665-4623 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.
- Molina Dual Options MyCare Ohio Medicaid Only: (855) 687-7862 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.

Members may also submit a Medicaid/Molina Dual Options MyCare Ohio Medicaid (opt-out) grievance in writing to:

Molina Healthcare of Ohio, Inc.
Attn: Appeals and Grievance Department
P.O. Box 349020
Columbus, OH 43234-9020Fax: (866) 713-1891

Members may also submit a Molina Dual Options MyCare Ohio (full benefits) grievance in writing to:

Molina Healthcare
Attn: Grievance and Appeals
P.O. Box 22816
Long Beach, CA 90801-9977

Fax: (562) 499-0610

Members may authorize a designated representative to act on their behalf (hereafter referred to as "representative"), with written consent. The representative can be a friend, a family member, health care Provider, or an attorney. An Authorized Representative Form can be found on Molina's Member website at MolinaHealthcare.com.

All grievances received will be kept confidential except as needed to resolve the issue and respond to the Member or representative.

Grievances Process and Timeline

Molina will investigate, resolve and notify the Member or representative of the findings. Every attempt will be made to resolve a grievance at the time of a call. However, if a grievance is unable to be resolved immediately, it will be resolved as expeditiously as possible, but no later than the following time frames:

- Two working days of receipt of a grievance related to accessing Medically Necessary Covered Services in the Medicaid or Molina Dual Options MyCare Ohio lines of business.
- 30 calendar days of receipt for grievances that are not Claims related in Medicaid or Molina Dual Options MyCare Ohio lines of business.
- 30 calendar days for grievances regarding bills or Claims in the Molina Dual Options MyCare Ohio line of business.
- 60 calendar days for grievances regarding bills or Claims in the Medicaid line of business.

Member Appeals

For Member appeals represented by the Provider, Molina must have written consent from the Member authorizing someone else to represent them. A determination will not be made if written consent is not received within 15 calendar days from the date the appeal was received. An Authorized Representative Form can be found on Molina's Member website at MolinaHealthcare.com. An appeal can be filed verbally or in writing within 60 days from the date of the Notice of Action. Molina will send a written acknowledgement in response to written appeal requests received. Molina will respond to the Member or representative in writing with a decision within 15 calendar days (unless an extension is granted to Molina by ODM).

The Member or representative should state the reason they feel the service should be approved and be prepared to provide any additional information for review. For a copy of the Grievance and Appeal Form, see the Forms tab on the Molina website at MolinaHealthcare.com/OhioProviders.

Appeals Process and Timeline

Molina has an expedited process for reviewing Member appeals when the standard resolution time frame could seriously jeopardize the Member's life, health or ability to attain, maintain, or regain maximum function.

Expedited Member appeals may be requested by the Member or representative orally or in writing. Molina will inform the Member or representative of the decision to treat the appeal as expedited within 24 hours of receipt. With few exceptions, an expedited Member appeal will be resolved as expeditiously as the Member's health condition requires, but will not exceed 72

hours from receipt, and the Member or representative will be notified. No punitive action will be taken against a Member or representative for filing an expedited Member appeal.

If Molina denies the request for an expedited resolution of an appeal, the appeal will be treated as a standard appeal and resolved within 15 calendar days from the receipt date (unless an extension was granted).

State Hearing

If the grievance resolution affirms the denial, reduction, suspension, or termination of a Medicaid-Covered Service, or if the resolution permits the billing of a Member due to Molina's denial of payment for that service, Molina will notify the Member of their right to request a state hearing.

A Member has the right to request a state hearing from the Bureau of State Hearings 90 days from the appeal resolution notice if there is dissatisfaction with Molina's decision. The Member or representative is required to file an appeal with Molina prior to requesting a state hearing.

Members are notified of their right to a state hearing in all the following situations:

- A service denial (in whole or in part)
- Reduction, suspension or termination of a previously authorized service
- A Member is being billed by a Provider due to a denial of payment and Molina upholds the decision to deny payment to the Provider

A health care Provider may act as the Member's authorized representative or as a witness for the Member at the hearing.

Appeal decisions not wholly resolved in the Member's favor will include information on how to request a state hearing and instructions on how to continue receiving benefits if benefits were denied until the time the state hearing is scheduled. If the state hearing upholds Molina's decision, and continued benefits were requested in the interim, the Member may be responsible for payment.

Reporting

Grievance and appeal trends are reported to the Quality Improvement Committee quarterly. This trend report includes a quantitative review of trends, qualitative or barriers analysis, and identification of interventions that address key drivers. An annual evaluation of grievance and appeal analysis is then completed and presented to the Quality Improvement Committee for evaluation. If required by the state or CMS, reporting is submitted to the Appropriate Agency as needed.

Record Retention

Molina will maintain all grievance and related appeal documentation on file for a minimum of 10 years. In addition to the information documented electronically via call tracking in Molina's centralized database or maintained in other electronic files, Molina will retain copies of any written documentation submitted by the Provider pertaining to the grievance/appeal process. Provider shall maintain records for a period not less than 10 years from the termination of the model contract and retained further if the records are under review or audit until the review or audit is complete. (Provider shall request and obtain Molina's prior approval for the disposition of records if Agreement is continuous.)

XVI. Provider Responsibilities

A. Nondiscrimination of Healthcare Service Delivery

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

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

B. Section 1557 Investigations

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

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

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

Should you or a Molina Member need more information, you can refer to the Health and Human Services website: federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

C. Facilities, Equipment and Personnel

The Provider's facilities, equipment, personnel and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable legal requirements including the accessibility requirements of the Americans with Disabilities Act (ADA).

D. Provider Data Accuracy and Validation

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

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

Providers must validate the Provider Online Directory (POD) information at least quarterly for correctness and completeness. Providers must notify Molina in writing (some changes can be made online) as soon as possible, but no less than 30 calendar days in advance of changes such as, but not limited to:

- Change in office location(s), office hours, phone, fax, or email.
- Addition or closure of office location(s).
- Addition or removal of a Provider (within an existing clinic/practice).
- Change in practice name, Tax ID and/or National Provider Identifier (NPI).
- Opening or closing the practice to new patients (PCPs only – see section on Provider Panel for further details).
- Any other information that may impact Member access to care.

Please visit our Provider Online Directory at MolinaHealthcare.com to validate your information. For corrections and updates, a convenient Provider Information Update Form can be found on the Provider Website. You can also notify your Provider Services Team or complete the Provider Information Update Form found on our Provider website under the "Forms" tab if your information needs to be updated or corrected.

Note: For Community Behavioral Health Organizations (Provider types 84 & 95), any additions, removals and changes/updates for employed rendering Providers (including specialty and degree changes) are to be submitted directly to ODM through the MITS system. ODM will then provide this information to Molina to update our systems. Please note that all agency-level updates are to be submitted directly to Molina using the options described in the previous paragraph.

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

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

E. National Plan and Provider Enumeration System (NPPES) Data Verification

CMS recommends that Providers routinely verify and attest to the accuracy of their National Plan and Provider Enumeration System (NPPES) data.

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

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

F. Molina Electronic Solutions Requirements

Molina strongly encourages 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 appeals and registration for and use of the Provider Portal.

Electronic Claims include Claims submitted via a Clearinghouse using the EDI process and Claims submitted through the Provider 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 Molina's Provider Portal within 30 days of entering the Molina network.

Molina is committed to complying with all HIPAA Transactions, Code Sets, and Identifiers (TCI) standards. Providers must comply with all HIPAA requirements when using electronic solutions with Molina. Providers must obtain a National Provider Identifier (NPI) and use their NPI in

HIPAA Transactions, including Claims submitted to Molina. Providers may obtain additional information by visiting Molina's HIPAA Resource Center located on our website at MolinaHealthcare.com.

Electronic Solutions/Tools Available to Providers

Electronic solutions/tools available to Molina Providers include:
- Electronic Claims submission options.
- Electronic Payment: EFT with ERA.
- Provider Portal.

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

G. Electronic Claims Submission Requirement

Molina strongly encourages participating Providers to submit Claims electronically whenever possible. Electronic Claims submission provides significant benefits to the Provider, such as:
- Promoting HIPAA compliance.
- Helping to reduce operational costs associated with paper Claims (printing, postage, etc.).
- Increasing accuracy of data and efficient information delivery.
- Reducing Claim processing delays as errors can be corrected and resubmitted electronically.
- Eliminating mailing time and enabling Claims to reach Molina faster.

Molina offers the following electronic Claims submission options:
- Submit Claims directly to Molina via the Provider Portal. See the Provider Portal Quick Reference Guide at provider.MolinaHealthcare.com or contact your Provider Services Team for registration and Claim submission guidance
- Submit Claims to Molina through your EDI Clearinghouse using Payer ID 20149, refer to our website, MolinaHealthcare.com/OhioProviders, for additional information.

While both options are embraced by Molina, submitting Claims via the Provider 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.

Provider Portal Claims submission includes the 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 Claim submission, see the Claims and Compensation section of this Provider Manual.

H. Electronic Payment (EFT/ERA) Requirement

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

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

I. Provider Portal

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

- Verify Member eligibility, covered services and view Healthcare Effectiveness Data and Information Set (HEDIS®) needed services (gaps).
- Claims:
  - Submit Professional (CMS-1500) and Institutional (UB-04) Claims with attached files.
  - Correct/Void Claims.
  - Add attachments to open or pending 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.
- View HEDIS® Scores and compare to national benchmarks.
- View a roster of assigned Molina Members for Primary Care Providers (PCPs).
- Download forms and access to an external link to applicable documents.
- Send/receive secure messages to/from Molina.

J. Balance Billing

Per federal law, Members who are dually eligible for Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the state or another payer such as a Medicaid Managed Care Plan is responsible for paying such amounts. The Provider is

responsible for verifying eligibility and obtaining approval for any services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. Balance billing a Molina Member for Covered Services is prohibited, other than for the Member's applicable copayment, coinsurance and deductible amounts. Members who are dually eligible for Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the state or another payer such as a Medicaid Managed Care Plan is responsible for paying such amounts.

K. Member Rights and Responsibilities

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

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

L. Procedure for Dismissing Non-Compliant Members

Providers may request that a Molina Member be dismissed from their practice if the Member does not respond to recommended patterns of treatment or behavior. Examples include missing scheduled appointments or failing to modify behavior that is disruptive, unruly, threatening or uncooperative.

The following steps need to be followed when dismissing a Member:

- Follow the Provider's Practice Dismissal Policy.
- Treat the Molina Member the same as a Member from another managed care plan.
- Following notification of dismissal, the PCP must offer coverage to the Member for a period of 30 days or until Molina assigns a new PCP to the Member, whichever is sooner.

This section does not apply if the Member's behavior is attributed to a physical or behavioral health condition.

M. Member Information and Marketing

Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all state and federal laws and regulations and approved by Molina prior to use. Please contact your Provider Services Team for information and review of proposed materials.

N. Member Eligibility Verification

Possession of a Molina ID card does not guarantee Member eligibility or coverage. Providers should verify eligibility of Molina Members prior to rendering services. Payment for services

rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

For more information please refer to the Eligibility, Enrollment and Disenrollment section of this Provider Manual**.**

O. Member Cost Share

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

P. Healthcare Services (Utilization Management and Care Management)

Providers are required to participate in and comply with Molina's Utilization Management and Care Management Programs, including all policies and procedures regarding Molina's facility admission, prior authorization, Medical Necessity review determination and Interdisciplinary Care Team (ICT) procedures. Providers will also cooperate with Molina in audits to identify, confirm and/or assess utilization levels of Covered Services.

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

Q. In Office Laboratory Tests

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

Additional information regarding In-Network Laboratory Providers and In-Network Laboratory Provider patient service centers is found on the laboratory Providers' respective websites:

- Quest at appointment.questdiagnostics.com/patient/confirmation.
- LabCorp at www.labcorp.com/labs-and-appointments.

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

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

R. Referrals

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

Providers should direct Molina Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed (if applicable) with Molina. In the case of urgent and Emergency Services, Providers may direct Members to an appropriate service including, but not limited to, primary care, urgent care and hospital emergency room. There may be circumstances in which referrals may require an out-of-network Provider. Prior authorization will be required from Molina except in the case of Emergency Services. For additional information please refer to the Healthcare Services section of this Provider Manual.

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

S. Treatment Alternatives and Communication with Members

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

T. Pharmacy Program

Providers are required to adhere to Molina's drug formularies and prescription policies. For additional information please refer to the Medicare Part D section of this Provider Manual.

U. Participation in Quality Programs

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

- Access to Care Standards.
- Site and Medical Record-Keeping Practice Reviews as applicable.
- Delivery of Patient Care Information.

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

V. Compliance

Providers must comply with all state and federal laws and regulations related to the care and management of Molina Members.

W. Confidentiality of Member Health Information and HIPAA Transactions

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

X. Participation in Grievance and Appeals Programs

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

For additional information please refer to the Appeals and Grievances section of this Provider Manual.

Y. Participation in Credentialing

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

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

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

Z. Delegation

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

AA. Primary Care Provider Responsibilities

PCPs are responsible to:

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

BB. Provider Panel

Participating Providers may only close their panels to new Molina Members when their panel is being closed to all new patients, regardless of insurer. Participating Providers must not close their panels to Molina Members only.

If a participating Provider chooses to close their panel to new Members, the Provider must provide 30 days advance notice to Molina. Written correspondence is required and must include the reason and the effective date of the closure. If the panel will not be closed indefinitely, correspondence should also include the re-open date.

If a reopen date for the panel is not known, the Provider will need to notify Molina when the office is ready to reopen the panel to new patients.

CC. Interpreter Services

Members with Limited English Proficiency (LEP), Limited Reading Proficiency (LRP), or Limited Hearing or Sight

Molina is dedicated to serving the needs of our Members and has made arrangements to ensure that all Members have information about their health care provided to them in a manner they can understand.

All Molina Providers are required to comply with Title VI of the Civil Rights Act of 1964 in the provision of Covered Services to Members. Compliance with this provision includes providing interpretation and translation services for Members requiring such services, including Members with LEP. Written procedures are to be maintained by each office or facility regarding their process for obtaining such services. Documentation of such services shall be kept in the Member’s chart.

Arranging for Interpreter Services

If a Member has LEP, the Provider may call Member Services for assistance with locating translation services. If a Member requires an on-site interpreter for sign language or foreign

interpretation, the Provider may call Provider Services to request assistance with locating interpreter services.

Pursuant to Title VI of the Civil Rights Act of 1964, services provided for Members with LEP, LRP, or limited hearing or sight are the responsibility of the Provider. Under no circumstances are Members to be held responsible for the cost of such services.

- If a Member cannot hear or has limited hearing ability, use the Ohio Relay Service/TTY at (800) 750-0750 or 711.
- If a Member has limited or no vision, documents in large print, Braille or audio can be obtained by calling Member Services.
- If a Member has LRP, contact Member Services.
    - The representatives will verbally explain the information, up to and including reading the document to the Member or provide the documents in audio version.

Provider Guidelines for Accessing Interpreter Services

When Molina Members need interpreter services for health care services the Provider should:

- Verify Member's eligibility and medical benefits.
- Inform the Member that interpreter services are available.
- Contact Molina immediately if assistance in locating interpreter services is needed.

DD. Disclosure Requirements

Providers are required to complete the Ownership and Control Disclosure Form during the contracting process and re-attest every 36 months or at any time disclosure must occur to ensure the information is correct and current. The forms are available on our Provider website at MolinaHealthcare.com/OhioProviders under the "Forms" tab in "Provider Forms" under "Contracted Practices/Groups Making Changes."

EE. Access to Care Standards

For more information on Access to Care Standards, refer to the "Access to Care Standards" section in the Quality section of this Provider Manual.

FF. Ohio Medicaid Addendum

In accordance with ODM requirements, Molina includes the Ohio Medicaid Addendum in each Provider contract. However, because the Medicaid Addendum is updated by ODM from time to time, a Provider's contract with Molina may contain an older version of the Addendum. If that is the case, please note that the Provider is required to abide by the terms and conditions of ODM's current Medicaid Addendum, which can be found on the ODM website at medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/managed-care/medicaid-addendum.

GG. MyCare Ohio: Ensuring Adequate COVID-19 Safety Protocols for Federal Contractors for Subcontracts Over the Simplified Acquisition Threshold of $250,000

a. Definition. As used in this clause "*United States or its outlying areas"* means:
The fifty States;
   1. The District of Columbia;
   2. The commonwealths of Puerto Rico and the Northern Mariana Islands;
   3. The territories of American Samoa, Guam, and the United States Virgin Islands; and
   4. The minor outlying islands of Baker Island, Howland Island, Jarvis Island, Johnston Atoll, Kingman Reef, Midway Islands, Navassa Island, Palmyra Atoll, and Wake Atoll.

b. Authority. This clause implements Executive Order 14042, Ensuring Adequate COVID Safety Protocols for Federal Contractors, dated September 9, 2021 (published in the Federal Register on September 14, 2021, 86 FR 50985).

c. Compliance. The Provider, a subcontractor, shall comply with all guidance, including guidance conveyed through Frequently Asked Questions, as amended during the performance of this Agreement, for contractor or subcontractor workplace locations published by the Safer Federal Workforce Task Force (Task Force Guidance) at saferfederalworkforce.gov/contractors/.

d. Subcontracts. The Provider shall include the substance of this clause, including this paragraph (d), in subcontracts at any tier that exceed the simplified acquisition threshold, as defined in Federal Acquisition Regulation 2.101 on the date of subcontract award, and are for services, including construction, performed in whole or in part within the United States or its outlying areas."

HH. Provider Enrollment (ODM Functions)

1. General Provider Information/Enrollment Information

Pursuant to 42 Code of Federal Regulations (CFR) 438.602, ODM is required to screen, enroll, and revalidate all MCO network Providers. This provision does not require MCO network Providers to render services to fee-for-service (FFS) beneficiaries.

There are many resources available on ODM website about the requirements to become a participating Provider. Please visit medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/enrollment-and-support/enrollment-and-support for several useful documents that answer relevant questions.

Organizational Provider types will be required to pay a fee. The fee does not apply to individual Providers and practitioners or practitioner groups. The fee is a federal requirement described in 42 CFS 445.460 and in OAC 5160:1-17.8. The fee for 2022 is $631 per application and is not refundable. The fee will not be required if the enrolling organizational Provider has paid the fee

to either Medicare or another state Medicaid agency within the past five years. However, Ohio Medicaid will require that the enrolling organizational Providers submit proof of payment with their application. (See OAC 5160:1-17.8)

Medicaid ID Requirements

In order to comply with federal rule 42 CFR 438.602, the ODM requires Providers at both the group practice and individual levels to be enrolled or apply for enrollment with Ohio Medicaid and to have an active Medicaid Identification (ID) Number for each billing National Provider Identifier (NPI).

For dates of service on or after Aug. 15, 2021, Molina denies Claims for unenrolled Providers. Providers will receive the following remit message, "N767 – The Medicaid state requires Providers to be enrolled in the Member's Medicaid state program prior to any Claim benefits being processed," and must take action to enroll or reactivate enrollment with ODM to continue receiving payment for rendering services to Molina Members.

Providers without a Medicaid ID number will need to submit an application to ODM. Enrollment is available through the Provider Network Management (PNM) system, or Providers can start the process at medicaid.ohio.gov.

2. Termination, Suspension, or Denial of ODM Provider Enrollment

For a list of termination, suspension and denial actions initiated by the state against a Provider or applicant that allow for hearing rights, please refer to Ohio Revised Code 5164.38.

For a list of termination, suspension and denial actions initiated by the state Medicaid agency against a Provider or applicant that allow for reconsideration, please refer to Ohio Administrative Code 5160-70-02.

3. Loss of Licensure

In accordance with Ohio Administrative Code 5160-1-17.6, a Medicaid Provider agreement will be terminated when any license, permit, or certification that is required in the Provider agreement or department rule has been denied, suspended, revoked, not renewed or is otherwise limited and the Provider has been afforded the opportunity for a hearing in accordance with the hearing process established by the official, board, commission, department, division, bureau, or other agency of state or federal government.

4. Enrollment and Reinstatement After Termination or Denial

If a Provider's Medicaid Provider agreement is terminated or an applicant's application is denied, the applicant/Provider should contact Ohio Medicaid via the Provider Enrollment Hotline at (800) 686-1516 to discuss the requirements to reapply. This process may include conversations with the ODM Compliance unit who will provide specific instruction on re-instatement requirements, if applicable.

5. Provider Maintenance

At a future date in 2023, the Provider Network Management (PNM) system will serve as the source of truth for Provider data for ODM and Molina. As a result, data in the PNM will be used in both the plan's Provider directory and ODM's Provider directory. To ensure Provider information remains current it is important for Providers to keep their information up to date in the PNM. Please remember, as an ODM Provider and in accordance with your Provider agreement, Providers are responsible to notify ODM of changes within 30 days (see OAC 5160-1-17.2 F).

Updating the PNM: When there is a change in a Provider's information, please log in to the PNM system, choose the Provider you are editing, and click the appropriate button to begin an update. Self-service functions include location changes, specialty changes, and key demographic (e.g., name, NPI, etc.) changes. This information is sent to the MCOs on a daily basis for use in their individual directories. The Provider must update their information in the PNM system first. The MCOs are required to direct Providers back to the PNM if there are changes.

For any Provider data changes prior to the effective date of the PNM as the source of truth for provider data, Providers must follow the notification process outlined on pages 183 and 184 of this Provider Manual.

6. Integrated Help Desk/ODM Provider Call Center

If you have questions or need assistance with your Ohio Medicaid Provider enrollment, call the ODM Provider Hotline at (800) 686-1516 through the interactive voice response (IVR) system. It provides 24 hour, 7 days a week access to information regarding Provider information. Provider Representatives are available via the IVR system weekdays from 8 a.m. through 4:30 p.m.

7. Helpful Information

- Medicaid Provider Resources

medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/enrollment-and-support/enrollment-and-support

- Federal guidelines for enrollment and screening (42 CFR 455 Subpart E) law.cornell.edu/cfr/text/42/part-455/subpart-E
- Ohio Revised Code
  codes.ohio.gov/ohio-revised-code/chapter-5160
  codes.ohio.gov/ohio-revised-code/chapter-3963
- Ohio Administrative Code
  codes.ohio.gov/ohio-administrative-code/5160

II. Provider Contracting (Molina Functions)

1. Information About the Contracting Process

Non-Contracted Providers who would like to join the Molina network are invited to complete and submit the Ohio Provider Contract Request Form available on the Molina Provider Website.

Sample Provider contracts are available on the "Forms" tab of the Molina Provider Website.

- Molina Healthcare Dental Provider Services Agreement
- Molina Healthcare Hospital Services Agreement
- Molina Healthcare Provider Services Agreement

2. Medicaid Addendum

The ODM Medicaid Addendum supplements the Base Contract or Agreement between the managed care organization and Provider and runs concurrently with the terms of the Base Contract or Agreement. The Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid Members. Attachments are only needed when Providers are offering different services or practitioners through this plan contract than are identified in the PNM system. Attachment A is needed for all PCPs to identify the Providers' capacity and service location. Attachment A is also required when a Provider has specific practitioner affiliates identified in the PNM who are agreeing to provide services under this plan contract. Attachment C is only required when the contract between the managed care entity and the Provider includes particular specialties rather than all specialties the Provider identified in the PNM system. The most current Medicaid Addendum is posted on the ODM website here: medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/managed-care/mc-policy/managed-care-program-appendix/managed-care-program-addenda. The addendum must be completed along with the MCO Provider contract.

3. Termination, Suspension, or Denial of Contract

Refer to your contract with Molina for details regarding termination or suspension of the contract. Molina reserves the right to deny Provider contracting requests based on the Provider network needs of our Members. A Provider who is denied a contract may apply again in one year.

4. Out-of-State Providers/Non-Contracted Providers

Out-of-state and non-contracted Providers should refer to the Non-Contracted Provider Billing Guidelines posted on Molina's website for information on:

- Prior Authorization (PA)
- Medicaid Authorization Reconsideration Process
- Prescription Drugs
- Contract Requests
- Emergency Services
- Post-Stabilization Services
- Referrals
- Benefits and Payment Policy
- Claim Submission (Medical and Behavioral Health Services)
- Timely Filing Guidelines for Medicaid
- Overpayments
- Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs)
- Member Eligibility Verification
- Sample Member Identification (ID) Cards
- Contact Information
- Cost Recovery

XVII. Medicaid: Pharmacy

Single Pharmacy Benefit Manager (SPBM)

The Single Pharmacy Benefit Manager (SPBM) is a specialized managed care program operating as a prepaid ambulatory health plan (PAHP) that will provide pharmacy benefits for the entire Medicaid managed care population (excluding MyCare Ohio Members). ODM selected Gainwell Technologies to serve as the SPBM. An additional integral component to the new pharmacy model is the Pharmacy Pricing and Audit Consultant (PPAC), which will conduct actual

acquisition cost surveys, cost of dispensing surveys, and perform oversight and auditing of the SPBM. ODM has selected Myers and Stauffer, LC as the PPAC vendor.

The SPBM will consolidate the processing of pharmacy benefits and maintain a pharmacy claims system that will integrate with the Ohio Medicaid Enterprise System (OMES), new MCOs, pharmacies, and prescribers. The SPBM also will work with pharmacies to ensure Member access to medications, supporting ODM's goals of providing more pharmacy choices, fewer out-of-network restrictions, and consistent pharmacy benefits for all managed care Members. SPBM will also reduce Provider and prescriber administrative burden, by using a single set of clinical policies and prior authorization procedures, as well as a single pharmacy program point of contact for all Members.

All Medicaid managed care Members will be automatically enrolled with the SPBM under a 1915(b) waiver. Additionally, Gainwell Technologies will be required to contract with all enrolled pharmacy Providers that are willing to accept the SPBM contract terms, resulting in a broad pharmacy network that will ensure access for all Members statewide.

SPBM will provide coverage for medications dispensed from contracted pharmacy Providers. Effective Oct. 1, 2022, Ohio Medicaid pharmacy claims must be billed to Gainwell. Any pharmacy claims billed to Molina will reject at the point of sale.

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.

For more information about the SPBM, training opportunities, or PPAC initiatives, please email: MedicaidSPBM@medicaid.ohio.gov or visit the SPBM website at spbm.medicaid.ohio.gov.

Single Pharmacy Benefit Manager (SPBM) Program Provider Responsibility

Providers are required to comply with established requirements for the ODM SPBM.

In accordance with Ohio Revised Code (ORC) section 5167.24, ODM has selected 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 MCO Members. The transition from pharmacy benefits being MCP-administered to SPBM-administered occurred on Oct. 1, 2022. Molina was responsible for providing and managing pharmacy benefits for their Members, including Members enrolled in the OhioRISE plan, in accordance with the Medicaid Provider Agreement and any state or federal regulations until the SPBM is implemented. Upon implementation of the SPBM, Pharmaceutical Drug Reporting requirements for all Covered Outpatient Drugs will continue to be required by Molina as stated in Appendix R of the ODM Provider Agreement.

Molina must collaborate with ODM and the SPBM on prescriber engagement strategies to educate and monitor Molina's network Providers regarding compliance with ODM's preferred drug list, prior authorization requirements, billing requirements, and appropriate prescribing practices. Molina must address noncompliance as it relates to adherence to the preferred drug list, failing to comply with prior authorization requirements, or operating outside industry or peer norms for prescribing practices.

The SPBM and MCOs will meet approximately twice monthly to discuss and address noncompliance as it relates to Provider/prescriber adherence to the preferred drug list, failing to comply with prior authorization requirements, or operating outside industry or peer norms for prescribing practices. The SPBM will present reporting during the twice monthly calls with all MCOs which will drive prescriber interventions and outreach strategies.

Opportunities identified for improvement from the twice monthly SPBM MCO workgroups identified above will be shared with ODM and MCOs at monthly ODM Pharmacy Director meetings.

XVIII. MyCare Ohio: Medicare Part D

A Part D coverage determination is a decision about whether to provide or pay for a Part D drug, a decision concerning a tiering exception request, a formulary exception request, a decision on the amount of cost sharing for a drug, or whether a Member has or has not satisfied a prior authorization or other UM requirement.

Any party to a coverage determination, (e.g., a Member, a Member's representative, or a Member's prescriber) may request that the determination be appealed. A Member, a Member's representative, or Provider are the only parties who may request that Molina expedite a coverage determination or redetermination.

Coverage determinations are either standard or expedited depending on the urgency of the Member's request.

Appeals/Redeterminations

When a Member's request for a coverage determination is denied, Members may choose someone (including an attorney, Provider, or other authorized representative) to serve as their personal representative to act on their behalf. After the date of the denial, a Member has up to 60 days to request a redetermination. This is the first level of appeal for Part D adverse decisions. Appeal data is confidential.

The redetermination request will be responded to within seven days. If an expedited appeal is required for an emergent situation, then the decision will be made within 72 hours of the request.

At any time during the appeal process, the Member or personal representative may submit written comments, papers or other data about the appeal in person or in writing. If the appeal/reconsideration is denied, the Member has the right to send the appeal to the Independent Review Entity (IRE) within 60 days of receipt of the appeal. The IRE has seven days to make a decision for a standard appeal/reconsideration and 72 hours for an expedited request. The IRE will notify Molina and the Member of the decision. When an expedited review is requested, the IRE will make a decision within 72 hours.

If the IRE changes the Molina decision, authorization for service must be made within 72 hours for standard appeals and within 24 hours for expedited appeals.

Payment appeals must be paid within 30 days from the date the plan receives notice of the reversal.

If the IRE upholds Molina's denial, they will inform the Member of their right to a hearing with the ALJ and will describe the procedures that must be followed to obtain an ALJ hearing.

CMS's IRE monitors Molina's compliance with determinations to decisions that fully or partially reverse an original Molina denial. The IRE is currently Maximums Federal Services, Inc.

Part D Prescription Drug Exception Policy

CMS defines a coverage determination as the first decision made by a plan regarding the prescription drug benefits a Member is entitled to receive under the plan, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request, and a decision on the amount of cost sharing for a drug.

An exception request is a type of coverage determination request. Through the exceptions process, a Member can request an off-formulary drug, an exception to the plan's tiered cost sharing structure, and an exception to the application of a cost UM tool (e.g., step therapy requirement, dose restriction, or prior authorization requirement).

Molina is committed to providing access to Medically Necessary prescription drugs to Members of Molina. If a drug is prescribed that is not on Molina's formulary, the Member or Member's representative may file for an exception. All exceptions and appeals are handled at the plan level (on-site) and are not delegated to another entity. Please see below for contact information by plan for personnel who handle the exceptions. Members or the Member's representatives (who can include Providers and pharmacists) may call, write, fax, or e-mail Molina's exception contact person to request an exception. Procedures and forms to apply for an exception may be obtained from the contact persons.

Part D Exceptions and Appeals Contact Information: call Molina at (800) 665-3086 or fax (866) 290-1309.

The Policy and Procedure for Exceptions and Appeals will be reviewed by a Pharmacy and Therapeutics (P&T) Committee on an annual basis at minimum. Exception/Prior Authorization criteria are also reviewed and approved by a P&T Committee.

1. **Formulary** – A formulary is a list of medications selected by Molina in consultation with a team of health care Providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Molina will generally cover the drugs listed in our formulary as long as the drug is Medically Necessary, the prescription is filled at a Molina network pharmacy, the prescription is being used for a medically accepted indication (i.e., either FDA approved or compendia supported for the diagnosis for which it is being used), and other plan rules are followed.

   Formularies may be different depending on the Molina plan and will change over time. Current formularies for all products may be downloaded from our website at MolinaHealthcare.com/OhioProviders.

2. **Copayments for Part D** – The amount a patient pays depends on which drug tier the drug is in under the plan and whether the patient fills the prescription at a preferred network pharmacy.
   - Most Part D services have a co-payment;
   - Co-payments cannot be waived by Molina per CMS; and,
   - Co-payments for Molina may differ by State and plan.

3. **Restrictions on Molina's Medicare Drug Coverage –** Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:
   - **Prior Authorization**: Molina requires prior authorization for certain drugs, some of which are on the formulary and also drugs that are not on the formulary. Without prior approval, Molina may not cover the drug.
   - **Quantity Limits**: For certain drugs, Molina limits the amount of the drug that it will cover.
   - **Step Therapy**: In some cases, Molina requires patients to first try certain drugs to treat a medical condition before it will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, Molina may not cover Drug B unless Drug A is tried first.
   - **Part B Medications**: Certain medications and/or dosage forms listed in this formulary may be available on Medicare Part B coverage depending upon the place of service and method of administration. Newly FDA approved drugs are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the Molina Pharmacy and Therapeutics Committee.

4. **Non-Covered Molina Medicare Part D Drugs**

- Agents when used for anorexia, weight loss, or weight gain (no mention of Medically Necessary).
- Agents when used to promote fertility.
- Agents used for cosmetic purposes or hair growth.
- Agents used for symptomatic relief of cough or colds.
- Prescription vitamins and minerals, except those used for prenatal care and fluoride preparations.
- Non-prescription drugs, except those medications listed as part of Molina's Medicare over-the-counter (OTC) monthly benefit as applicable and depending on the plan.
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale.
- Molina Members with Medicaid coverage may have a limited selection of these excluded medications as part of its Medicaid coverage for Members assigned to Molina Medicaid.
- Prescriptions that are not being used for a medically accepted indication (i.e., prescriptions must either be FDA-approved, or compendia supported for the diagnosis for which they are being used; the Medicare-approved compendia are American Hospital Formulary Service Drug Information (AHFS) and DRUGDEX® Information System).

5. **There may be differences between the Medicare and Medicaid Formularies**. The Molina Formulary includes many injectable drugs not typically found in its Medicaid formularies such as those for the aged, blind and disabled.

6. **Requesting a Molina Medicare Formulary Exception** – Molina Medicare product drug prior authorizations are called Exceptions, which are required when your patient needs a drug that is not on the Formulary. A Member, a Member's appointed representative or a Member's prescribing Provider are permitted to file an Exception. (The process for filing an Exception is predominantly a fax-based system.) The form for Exception requests is available on the Molina website.

7. **Requesting a Molina Medicare Formulary Redetermination (Appeal)** –The appeal process involves an adverse determination regarding Molina issuing a denial for a requested drug or Claim payment. If the Member received a Notice of Denial of Medicare Prescription Drug Coverage and disagrees with the decision rendered, they may request a redetermination (appeal) from Molina by completing the appeal form sent with the Notice of Denial.

   A Member, a Member's appointed representative or a Member's prescribing Provider (for expedited appeals) may complete the appeal form and submit any information which may help Molina with the processing of the appeal. An appeal must be submitted in writing and filed within 60 calendar days from the date that the determination was rendered.

- A standard appeal may be submitted to Molina in writing. The appeal will be reviewed upon receipt and the Member will be notified in writing within seven calendar days from the date the request for re-determination is received.
- An expedited appeal can be requested by the Member or by a Provider acting on behalf of the Member in writing or can be taken over the phone. An expedited appeal may be requested in situations where applying the standard time frame could seriously jeopardize the Member's life, health or ability to regain maximum function. If a Provider supports the request for an expedited appeal, Molina will honor this request.
- If a Member submits an appeal without Provider support, Molina will review the request to determine if it meets Medicare's criteria for expedited processing. If the plan determines that the request meets the expedited criteria, Molina will render a decision as expeditiously as the Member's health requires, but not exceeding 72 hours. If the request does not meet the expedited criteria, Molina will render a coverage decision within the standard redetermination time frame of seven calendar days.
- To submit a verbal request, please call (800) 665-3086. Written appeals must be mailed or faxed to (866) 290-1309.

8. **Initiating a Part D Coverage Determination Request** – Molina will accept requests from Providers or a Member's appointed representative on the behalf of the Member either by a written or verbal request. The request may be communicated through the standardized Molina Medication Prior Authorization Request Form or through telephone via fax and telephone lines. All requests will be determined and communicated to the Member and the Member's prescribing Provider with an approval or denial decision within 72 hours/three calendar days after Molina receives the completed request.

   Molina will request submission of additional information if a request is deemed incomplete for a determination decision. All requests may be approved by: 1) Molina Pharmacy Technician under the supervision of a pharmacist; 2) Molina Pharmacist; or, 3) Chief Medical Officer (CMO) of Molina. Review criteria will be made available at the request of the Member or their prescribing Provider. Molina will determine whether a specific off-label use is a medically accepted indication based on the following criteria:

   a. A prescription drug is a Part D drug only if it is for a medically accepted indication, which is supported by one or more citations included or approved for inclusion with the following compendia:
      - American Hospital Formulary Service Drug Information
      - DRUGDEX® Information System
   b. Requests for off-label use of medications will need to be accompanied with excerpts from one of the two CMS-required compendia for consideration. The submitted excerpts must cite a favorable recommendation.

c. Depending upon the prescribed medication, Molina may request the prescribing Provider to document and justify off-label use in clinical records and provide information such as diagnostic reports, chart notes, and medical summaries.

Denial decisions are only given to the Member or Member's representative by a Pharmacist or CMO of Molina. The written denial notice to the Member (and the prescriber involved) includes the specific rationale for denial; the explanation of both the standard and expedited appeals process; and, an explanation of a Member's right to, and conditions for, obtaining an expedited appeals process.

If Molina denies coverage of the prescribed medication, Molina will give the Member a written notice within 72 hours explaining the reason for the denial and how to initiate the appeals process. If no written notice is given to the Member within the specified timeframe, Molina will start the next level of appeal by sending the Coverage Determination request to the IRE within 24 hours.

If a coverage determination is expedited, Molina will notify the Member of the coverage determination decision within the 24-hour timeframe by telephone and mail the Member a written Expedited Coverage Determination within three calendar days of the oral notification. If Molina does not give the Member a written notification within the specified timeframe, Molina will start the next level of appeal by sending the Coverage Determination request to IRE within 24 hours.

9. **Initiating a Part D Appeal** – If Molina's initial coverage determination is unfavorable, a Member may request a first level of appeal, or re-determination within 60 calendar days from the date of the notice of the coverage determination. In a standard appeal, Molina has up to seven days to make the re-determination, whether favorable or adverse, and notify the Member in writing within seven calendar days from the date the request for re-determination is received. Members or a Member's prescribing Provider may request Molina to expedite a redetermination if the standard appeal timeframe of seven days may seriously jeopardize the Member's life, health, or ability to regain maximum function. Molina has up to 72 hours to make the re-determination, whether favorable or adverse, and notify the Member in writing within 72 hours after receiving the request for re-determination. If additional information is needed for Molina to make a re-determination, Molina will request the necessary information within 24 hours of the initial request for an expedited re-determination. Molina will inform the Member and prescribing Provider of the conditions for submitting the evidence since the timeframe is limited on expedited cases.

10. **The Part D Independent Review Entity (IRE)** – If the re-determination is unfavorable, a Member may request reconsideration by the IRE. The Part D Qualified Independent Contractor is currently MAXIMUS Federal, a CMS contractor that provides second level appeals.
    - Standard Appeal: The IRE has up to seven days to make the decision.

- Expedited Appeal: The IRE has up to 72 hours to make the decision.
- Administrative Law Judge (ALJ): If the IRE's reconsideration is unfavorable, a Member may request a hearing with an ALJ if the amount in controversy requirement is satisfied. Note: Regulatory timeframe is not applicable on this level of appeal.
- Medicare Appeals Council (MAC): If the ALJ's finding is unfavorable, the Member may appeal to the MAC, an entity within the Department of Health and Human Services that reviews ALJ's decisions. Note: Regulatory timeframe is not applicable on this level of appeal.
- Federal District Court (FDC) – If the MAC's decision is unfavorable, the Member may appeal to a federal district court, if the amount in controversy requirement is satisfied. Note: Regulatory timeframe is not applicable on this level of appeal.

Pain Safety Initiative (PSI) Resources

Safe and appropriate opioid prescribing and utilization is a priority for all of us in health care. Molina requires Providers to adhere to Molina's drug formularies and prescription policies designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to Members regarding opioid and pain safety as needed.

Molina is dedicated to ensuring Providers are equipped with additional resources, which can be found on the Molina Provider website. Providers may access additional Opioid-safety and Substance Use Disorder resources at MolinaHealthcare.com under the Health Resource tab. Please consult with your Provider Services Team or reference the medication formulary for more information on Molina's Pain Safety Initiatives.

XIX. Risk Adjustment Management Program

What is Risk Adjustment?

The Centers for Medicare & Medicaid Services (CME) defines Risk Adjustment as a process that helps accurately measure the health status of a plan's membership based on medical conditions and demographic information.

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

Why is Risk Adjustment Important?

Molina relies on our Provider Network to take care of our Members based on their health care needs. Risk Adjustment looks at a number of clinical data elements of a Member's health

profile to determine any documentation gaps from past visits and identifies opportunities for gap closure for future visits. In addition, Risk Adjustment allows us to:

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

Your Role as a Provider

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

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

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

Interoperability

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

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

Provider will participate in Molina's program to communicate Clinical Information using the Direct Protocol. Direct Protocol is the Health Insurance Portability and Accountability Act

(HIPAA) compliant mechanism for exchanging healthcare information that is approved by the Office of the National Coordinator for Health Information Technology (ONC).

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

RADV Audits

As part of the regulatory process, state and/or federal agencies may conduct Risk Adjustment Data Validation (RADV) audits to ensure that the diagnosis data submitted by Molina is appropriate and accurate. All Claims/encounters submitted to Molina are subject to state and/or federal and internal health plan auditing. If Molina is selected for a RADV audit, Providers will be required to submit medical records in a timely manner to validate the previously submitted data.

Contact Information

For questions about Molina's Risk Adjustment Programs, please contact your Molina Provider Team.

XX. Appendix A

A. Medicaid and MMP Benefits Index

All Covered Services must be Medically Necessary. Some are subject to prior authorization (PA) requirements and limitations. All services rendered by non-participating Providers, excluding emergency and urgent care, require PA. Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the Member's eligibility, benefit limitation/exclusions, evidence of Medical Necessity during the Claim review, and Provider status with Molina Healthcare of Ohio.

If more information is needed, contact Molina Provider Services at (855) 322-4079.

Services Benefit Coverage Information:

- Abortion
  - Covered when Medically Necessary to save the life of the Member or in instances of reported rape or incest, as noted in OAC 5160-17-01.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
  - Abortion Certification Form ODM 03197, available on the Provider Website, is required.

- Acupuncture
  - Coverage is limited to the pain management of migraine headaches and lower back pain.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Alcoholism Treatment
  - Molina will cover inpatient or outpatient treatment for medical conditions resulting from or associated with alcoholism or chemical dependency.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Ambulance and Wheelchair Services
  - Covered.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Antigen (Allergy Serum)
  - Covered.
- Attention Deficit Disorder (ADD)
  - If treated by PCP, pediatrician or neurologist, covered as a medical condition.
  - If treated by a psychiatrist or other Mental Health (MH) professional see Behavioral Health below.
- Behavioral Health
  - Covered.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Biofeedback
  - Covered.
  - Additional Information: See Molina's PA Code List on the Provider Website.
- Birth Control
  - Oral contraceptive drugs are covered by Ohio Medicaid.
  - Certain contraceptive devices and injections are covered by Molina.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Birthing Centers
  - Covered.
- Blood Products
  - Covered Services include blood, blood components, human blood products, and their administration.
- Braces (Orthodontics)
  - Covered for children under the age of 20 and subject to medical review and limitations.
  - If prior authorized and started by another Provider, services related to the braces are covered through the end of the period initially authorized for the braces.
  - For additional information contact SKYGEN USA, LLC, formerly known as Scion Dental, Inc.
- Braces (Orthopedic)
  - Covered. Replacement subject to medical review and limitations.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Breast Implants

  - Covered when deemed Medically Necessary for medical complications. See Reconstructive Surgery.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Breast Implant Removal
  - Covered when deemed Medically Necessary for medical complications.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Breast Reductions
  - Covered when deemed Medically Necessary as a result of medical complications.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Cardiac Rehab
  - Covered only after a cardiac event.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Chemical Dependency
  - Inpatient or outpatient treatments for medical conditions resulting from or associated with alcoholism or chemical dependency are covered.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Chemotherapy
  - Covered.
  - Experimental or investigational treatment is not covered.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Chiropractic Care
  - Payment for manual manipulation of the spine may be made only for the correction of a subluxation, the existence of which must be determined either by physical examination or by diagnostic imaging.
- Circumcision
  - Newborn: Covered.
  - Adults: Covered if Medically Necessary.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Contact Lenses
  - Not covered for routine vision correction.
  - Covered when Medically Necessary.
  - Additional Information: Covered one time per year for ages 0 to 20, 60+, and covered once every 2 years for ages 21-59.
- Counseling
  - See Behavioral Health.
- Court Ordered Treatment
  - Must be Covered Service and Medically Necessary.
- Custodial Care
  - Covered under MyCare Ohio Medicaid Only.
- Dental Care
  - Cleaning/checkup once every 6 months is covered for adults and children.

  - Removal of impacted wisdom teeth and emergency tooth re-implantation for adults is covered.
  - Dentures, partial plates and braces require PA and are subject to medical review and limitations. Dentures and plates may be replaced every eight years.
  - For specific coverage information regarding extraction, restorative services and medical services related to dental care, contact Provider Services.
  - For additional information contact SKYGEN USA, LLC, formerly known as Scion Dental, Inc.
- Diabetes Education
  - Covered.
- Diabetic Supplies
  - Covered.
  - Additional Information: Pharmacy benefit.
- Dialysis
  - Hemodialysis or other appropriate procedures or treatment of renal failure including equipment are covered.
  - Additional Information: Notification is required.
- Diapers
  - Diapers are covered if Medically Necessary for enrollees age 3 and older.
- Durable Medical Equipment (DME)
  - Certain DME are covered by Ohio Medicaid. Prosthetic and orthotic devices, orthopedic appliances and braces, breast pumps, selected medical supplies, oxygen and related equipment are covered.
  - Incontinence supplies (other than diapers) are covered for enrollees older than 3 years of age.
  - See the Medicaid Supply List at OAC 5160-10-01 Appendix A.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Eating Disorders
  - Medically Necessary treatment of eating disorders such as bulimia and anorexia nervosa are covered.
  - Also see Behavioral Health, Obesity and/or Weight Loss.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Emergency Department Services
  - Emergencies and urgent care are covered.
  - When a consumer moves or is temporarily staying outside the service area, coverage shall be limited to emergent and urgent care, including unplanned labor and delivery out of area.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Experimental Treatment or Devices
  - Not covered.
- Fertility Drugs

  - Not covered for infertility services defined in OAC 5160-21-02 Reproductive health services: pregnancy prevention, (C) (1).
- Formula/ Enteral Feeding
  - Covered if prescribed by a physician and determined to be Medically Necessary.
  - Standard infant formula not covered. Refer consumer to Women, Infants and Children (WIC) Program for assistance with infant formula.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Gastroplasty
  - Gastroplasty, gastric stapling or ileo-jejunal shunt are covered only for morbid obesity when certain medical complications or conditions are present following ODM guidelines.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Genetic Testing
  - Genetic testing to evaluate the risk of familial disease or inherited disorder is covered. Paternity testing and forensic testing are not covered.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Glucometers and related supplies
  - Covered.
  - Additional Information: Pharmacy benefit.
- Health Education
  - Health education and nutritional counseling for specific conditions such as diabetes, high blood pressure and anemia are covered.
  - Education by the PCP as part of Healthchek EPSDT for children is also covered.
  - Additional Information: Must be obtained from network Providers.
- Hearing Aids
  - Covered. Must meet specific criteria and is limited to one hearing aid per four years for adults. Hearing aids are covered as Medically Necessary for children.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Home Health Aide
  - Covered when Medically Necessary.
- Home Health Care
  - Skilled home health services are covered when provided through network agencies. The first three visits do not require a PA; however, a Certificate of Medical Necessity (CMN) is required to be on file with the Provider.
  - Additional Information:
    - A face-to-face encounter must be done 90 days prior to start of care or within 30 days following the start of care.
    - The treating physician must complete a CMN, Form ODM 07137.
    - See Molina's PA Code Lists on the Provider Website.
- Home Health Services for Member and Baby after Delivery

  - Member and baby can have up to two home health care visits (G0154) within the baby's first 28 days of life only without a PA, provided the appropriate diagnosis code(s) are billed on the Claim(s).
- Hospice & Palliative Care
  - Covered when provided through network agencies for consumers with life expectancy of less than six months.
  - Additional Information: Notification is required.
- Hospitalization
  - Covered.
  - Consumers scheduled for elective procedures must be admitted to network facilities (unless the service cannot be safely performed in a network facility and is approved in advance by Molina).
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Hysterectomy
  - Consent to Hysterectomy Form (JFS 03199) required except in unique circumstances of an unscheduled clinical event that requires a hysterectomy because of a life-threatening emergency. The Consent to Hysterectomy Form is available on the Molina Provider Website.
  - See OAC 5160-21-02.2 Medicaid Covered Reproductive Health Services: Permanent Contraception/Sterilization Services and Hysterectomy.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Immunizations
  - Routine immunizations (those included in the Vaccines for Children) are covered.
  - Immunizations required for travel outside the United States are not covered.
  - Additional Information: See OAC 5160-4-12 Immunizations, Injections and Infusions (Including Trigger-Point Injections), and Provider-Administered Pharmaceuticals.
- Impotence Treatment
  - Not covered for impotence treatment defined in OAC 5160-21-02 Reproductive health services: pregnancy prevention, (C) (1).
- Incarcerated Members
  - Services provided to Members while incarcerated are generally not covered.
  - If incarcerated more than 15 days, the consumer is disenrolled from Molina.
- Infertility Testing and Treatment
  - Not covered for infertility testing and treatment defined in OAC 5160-21-02 Reproductive health services: pregnancy prevention, (C) (1).
- Learning Disorders
  - See Neuro-developmental Therapy section.
  - Refer to Children with Medical Handicaps.
- Mammogram
  - Covered for a Member 35 years of age or older, unless the Member is at high-risk of developing breast cancer.
  - One screening mammography for Member 34 to 40 years of age.

  - One screening mammography every 12 months may be paid for a Member who is over the age of 39.
  - Mammography's provided for the diagnosis and treatment for a Member who shows clinical symptoms indicative of breast cancer are covered regardless of the recipient's age.
  - Additional Information: See OAC 5160-4-25 Laboratory and Radiology Services.
- Massage Therapy
  - Not covered.
- Maternity Care
  - Covered.
- Mental Health
  - Covered.
  - The following services are not covered:
    - Sexual or marriage counseling
    - Sensitivity training, encounter groups or workshops
    - Sexual competency training
    - Marathons and retreats for mental disorder
    - Educational activities, testing and diagnosis
    - Monitoring activities of daily living
    - Recreational therapy (e.g., art, play, dance or music)
    - Teaching grooming skills
    - Services primarily for social interaction, diversion, or sensory stimulation
    - Psychotherapy services are not covered if the patient's cognitive deficit is too severe to establish a relationship with the psychotherapist
  - Additional Information: Members may be seen by network behavioral health Providers up to 12 office visits for adults ages 21 and older and 20 visits for children ages 0 to 20 in a calendar year without PA.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Military Service-Related Disabilities
  - Services provided through network Providers are covered.
  - Care obtained at Veterans Administration facilities is covered through the Veterans Administration Program.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Naturopathy
  - Not covered.
- Neuro-developmental Therapy
  - Covered by plan under the therapy benefit if obtained through participating Provider.
  - Medical review and limitations apply. Member must show continued improvement in order to be considered medically appropriate.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Norplant-Implantable Contraceptives

  - U.S. Food and Drug Administration (FDA)-approved implantable contraceptives are covered.
- Nursing Homes
  - See Skilled Nursing Facilities section.
- Nursing Facility Ventilator
  - Medicaid primary Members in nursing facilities that are ventilator dependent.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Nutritional Counseling
  - Nutritional counseling is covered for specific conditions such as diabetes, high blood pressure and anemia.
  - Counseling by dieticians is covered for children with growth disorders, metabolic diseases and inadequate dietary intake per Healthchek EPSDT guidelines.
  - Additional Information: Commercial weight loss programs (such as Weight Watchers, Jenny Craig) are not covered.
- Obesity Treatment (See also Gastroplasty or Weight Loss sections)
  - Gastric bypass surgery is covered at a participating inpatient Molina facility when certain medical complications/conditions are present following ODM guidelines.
  - Gastroplasty, gastric stapling, or ileo-jejunal shunt could be deemed Medically Necessary if medical complications or conditions, in addition to the obesity, are present.
  - Counseling by dieticians for the following are covered: children with growth disorders, metabolic diseases and inadequate dietary intake per Healthchek EPSDT guidelines.
  - Additional Information: Commercial weight loss programs (such as Weight Watchers, Jenny Craig) are not covered.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Observation Services
  - Services performed in conjunction with outpatient observation services.
- Occupational Therapy (See also Neuro- developmental Therapy)
  - Medically Necessary therapy for restoration or maintenance of function affected by illness, disability, condition or injury is covered.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Oral Surgery
  - Medical treatments related to oral conditions such as infections, temporomandibular joint (TMJ) disorders, cleft palate, and post-accident surgeries are covered by Molina.
  - Oral surgery for cosmetic purposes is not covered.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Organ Transplants
  - Transplants which are medically indicated for specific diagnoses are covered if approved by the Ohio Transplant Consortium.
  - Due to the complexity of transplant coverage decisions, the physician should contact Molina Utilization Management for specific information on transplant coverage.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Orthotics

  - Covered.
  - See DME section.
  - Shoe inserts are not covered.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Out-of-Area Care
  - When an enrollee moves or is temporarily staying outside the service area, coverage shall be limited to emergent and urgent care, including unplanned labor and delivery.
  - Emergencies and urgent care are covered within the U.S.
- Outpatient Surgery
  - Covered.
  - Additional Information: Some exclusions apply. See Molina's PA Code Lists on the Provider Website.
- Oxygen
  - Oxygen, respiratory equipment and supplies are covered.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Opioid Treatment Program
  - Covered.
  - Additional Information: ODM Opioid Treatment Manual.
- Pain Clinics
  - Covered when Medically Necessary.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Pap Smears
  - Covered.
- Physical Exams
  - Routine wellness exams by the PCP, including Healthchek EPSDT exams and annual adult physicals, are covered.
- Physical Therapy (See also Neuro- developmental Therapy section)
  - Medically-necessary therapy for restoration or maintenance of function affected by illness, disability, condition or injury is covered.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Plastic Surgery (See also Reconstructive Surgery section)
  - Covered when deemed Medically Necessary for constructive surgery to correct a functional disorder resulting from a disease state, congenital disease or accidental injury.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Podiatry
  - No limit for peripheral vascular disease and diabetes. Not covered for routine podiatry services.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Pre-existing Conditions
  - Covered, if not specifically excluded.
- Pregnancy and Delivery

  - Covered.
  - Additional Information: Notification is required.
- Prenatal Care
  - Covered.
- Prescriptions: Medicaid
  - All Medically Necessary physician-administered drugs are covered by Molina per OAC 5160-26-03.
- Prescriptions: MyCare Ohio
  - All Medically Necessary prescription drugs are covered.
  - Additional Information: See Molina's Preferred Drug List (PDL) for PA requirements available on the Molina Provider Website.
- Preventive Care
  - Services are covered according to Molina's Preventive Health Guidelines.
- Prostate Testing
  - Covered according to Molina's Preventive Health Guidelines or as needed to diagnose prostate cancer.
- Psychiatric Disorders
  - See Behavioral Health section.
- Reconstructive Surgery
  - Covered when deemed Medically Necessary to correct a functional disorder resulting from a disease state, congenital disease, or accidental injury.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Respite Care/BH Respite
  - With the implementation of revised OAC 5160-26-03 Managed Health Care Programs: Covered Services, the eligibility criteria for children with long-term services and supports (MLTSS) needs have been updated. Behavioral health eligibility criteria were added to allow children with a severe emotional disturbance (SED) diagnosis to access respite services. Refer to OAC Rule 5160-26-03.2 for additional details regarding MLTSS respite services for children and OAC Rule 5160-59-03.4 OhioRISE: behavioral health respite services for children.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Second Opinions
  - Covered through network Providers.
  - Additional Information: Arrange through Member Services.
- Skilled Nursing Facilities
  - Covered for short-term rehabilitative stay as determined by ODM.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Sleep Studies
  - Covered as a medical condition if Medically Necessary and meets review criteria.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Smoking Cessation
  - Nicotine Replacement Medications are covered by ODM.

  - Members should also enroll in a Smoking Cessation Program to increase the likelihood of success. Molina's Smoking Cessation Program is for Members who are ready to quit, and it is available at no cost to them. To participate in the program, Members can contact Member Services.
- Speech Therapy (See also Neuro -developmental Therapy section)
  - Covered for Medically Necessary therapy for restoration or maintenance of function affected by illness, disability, condition or injury.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Spinal Manipulations
  - Covered with limitations. See Chiropractic Care.
- Specialized Recovery Services (SRS) Program
  - Recovery Management.
  - Individualized Placement and Support – Supported Employment (IPS-SE).
  - Peer Recovery Support.
  - Covered with limitations. See Specialized Recovery Services (SRS) Program.
  - Additional Information: See Molina's PA Code Lists on the Provider website, the ODM Behavioral Health Provider Manual or OAC 5160-43 Specialized Recovery Services Program.
- Sterilization (Tubal Ligation or Vasectomy)
  - Covered for patients 21 years of age or older.
  - Consent to Sterilization Form (HHS-687 or Spanish version HHS-687-1) required except in unique circumstances of an unscheduled clinical event that requires sterilization because of a life-threatening emergency. The Consent to Sterilization Form is available on the Molina Provider Website.
  - Must be a voluntary request, and the individual must be mentally competent. Reversal is excluded.
  - See OAC 5160-21-02.2 Medicaid Covered Reproductive Health Services: Permanent Contraception/Sterilization Services and Hysterectomy.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Surgery Office Based
  - Covered surgical procedures performed in the office.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Surrogacy Services
  - Not covered.
- Supplies (Non- Durable)
  - Must have a written prescription. Some limitations apply.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Telemedicine/Telehealth
  - Evaluation and Management Services:
    - Office or other outpatient services.
    - Office or other outpatient consultations or inpatient consultations.

        - Psychiatry services such as: Psychiatric diagnostic procedures, psychotherapy, pharmacologic management or interactive complexity.
    - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Temporomandibular Joint (TMJ) Syndrome
    - Covered if meets certain specifications.
    - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Transportation
    - Up to 30 one-way/15 round-trips per calendar year for Medically Necessary appointments and WIC or CDJFS Medicaid redetermination appointments.
    - Transportation is also available if the Member lives greater than 30 miles from the nearest network Provider.
    - Additional Information: Arranged through Transportation Services. Call at least two business days before the appointment.
- Gender Transition
    - Covered.
    - Additional Information: Only when Medically Necessary under section 92.207(d) of 81 Federal Register (FR) 31471-72.
- Travel Immunizations
    - Not covered.
- Urgent Care
    - Covered.
- Vaccination (Immunization)
    - Covered.
    - (See also Travel Immunizations section).
- Vasectomy
    - See Sterilization.
- Vision
    - Eye Exams:
        - Medicaid: One eye examination is covered every 12 months
        - MyCare Ohio: One eye examination is covered every 12 months for Members 20 and younger, and Members 60 and older; one eye examination covered every 24 months for Members ages 21 to 59
    - Eye Glasses:
        - Medicaid: Replacement frames and lenses every 12 months due to normal wear and tear or when Medically Necessary
        - MyCare Ohio: One complete frame and pair of lenses, just lenses or just frames, or contact lenses with prior approval
            - One every 12 months for Members 20 and younger, and Members 60 and older
            - One every 24 months for Members ages 21 to 59
    - Vision correction surgery (radial keratotomy, Lasik) is excluded.
    - Additional Information: Must be obtained through a network Provider.
    - Additional Information: Please contact March Vision.

- Weight Loss
  - Medically Necessary weight loss is covered at a participating network inpatient Molina facility when certain medical complications/conditions are present.
  - Subject to medical review.
  - Counseling by dieticians is covered for children with the following: growth disorders, metabolic diseases and inadequate dietary intake per Healthchek EPSDT guidelines.
  - See Obesity Treatments section.
  - Additional Information: Commercial weight loss programs (such as Weight Watchers, Jenny Craig) are not covered.
  - Additional Information: Gym memberships are not covered.
  - Additional Information: See Molina's PA Code Lists on the Provider Website.
- Well Adult Exams
  - Yearly well adult examinations are covered.
  - Not covered when required for employment or for other insurance coverage.
- Well Child Exams
  - Covered.

B. Community Behavioral Health Services

Behavioral health counseling and therapy services means interaction with a person with the focus on treatment of the person's mental illness or emotional disturbance. When the person served is a child or adolescent, the interaction may also be with the family members and/or parent, guardian and significant others when the intended outcome is improved functioning of the child or adolescent and when such interventions are part of the Individualized Service Plan (ISP). Managed care plans have the potential to improve service coordination, provide greater flexibility in types of services, and help to control costs through reduced reliance on hospitalization and institutionalization for beneficiaries who are mentally ill.

Behavioral health counseling and therapy service shall consist of a series of time-limited, structured sessions that work toward the attainment of mutually defined goals as identified in the ISP.

Providers must bill the unit increments based on the standard CPT/HCPCS coding rules. For 15-minute units, continue to round to the nearest whole unit and for 60-minute units, round to the nearest tenth of a unit (six-minute increments). Medications should be billed in number of units dispensed. A complete billing guide and other reference documents can be found on the Office of Health Transformation website for Medicaid Behavioral Health Redesign at bh.medicaid.ohio.gov/manuals.

Effective for dates of service on and after Jan. 1, 2018, those practitioners independently licensed by a professional board are **required** to be reported using their personal NPI as the rendering practitioner. Listed below are the Ohio licensed practitioners with their corresponding Medicaid Provider type/specialty code in parentheses:

- Physicians (MD/DO), Psychiatrists (20)
- Physician Assistants (24)
- Licensed Independent Social Workers (37)
- Registered Nurses (38-384)
- Licensed Practical Nurses (38-385)
- Licensed Psychologists (42)
- Licensed Professional Clinical Counselors (47)
- Licensed Independent Marriage and Family Therapists (52)
- Licensed Independent Chemical Dependency Counselors (54)
- Clinical Nurse Specialists (65)
- Certified Nurse Practitioners (72)

Effective for dates of service on and after July 1, 2018, rendering practitioners will also include the behavioral health practitioners listed below with Medicaid Provider type/specialty codes in parentheses.

- Licensed Social Workers (37/371)
- Social Worker Trainee (37/372)
- Social Worker Assistant (37/373)
- Psychology Trainee (42/422)
- Psychology Assistant (42/423)
- Psychology Intern (42/424)
- Chemical Dependency Counselor II (54/541)
- Chemical Dependency Counselor III (54/542)
- Chemical Dependency Counselor Asst (54/543)
- Licensed Professional Counselors (47/471)
- Counselor Trainee (47/472)
- Licensed Marriage and Family Counselor (52/521)
- Marriage and Family Counselor Trainee (52/522)
- Qualified MH Specialist (96/960)
- Qualified MH Specialist 3 (96/961)
- Care Management Specialist (96/962)
- Peer Recovery Supporter (96/963)

Practitioner NPIs are **required** in the rendering field effective for dates of service on and after July 1, 2018. Some modifiers that indicate practitioner will continue to be required.

Practitioner Providing the Service

- Licensed Professional Counselor (LPC): Practitioner Modifier U2
- Licensed Chemical Dependency Counselor II (LCDC II): Practitioner Modifier U3
- Licensed Chemical Dependency Counselor III (LCDC III): Practitioner Modifier U3

- Licensed Social Worker (LSW): Practitioner Modifier U4
- Licensed Marriage and Family Therapist (LMFT): Practitioner Modifier U5
- Psychology Assistant, Intern, Trainee (PSY Asst): Practitioner Modifier U1
- Chemical Dependency Counselor Assistant (CDC-A): Practitioner Modifier U6
- Counselor Trainee (C-T): Practitioner Modifier U7
- Social Worker Assistant (SW-A): Practitioner Modifier U8
- Social Worker Trainee (SW-T): Practitioner Modifier U9
- Marriage and Family therapist Trainee (MFT-T): Practitioner Modifier UA
- QMHS – High School (QMHS): Practitioner Modifier HM
- QMHS – Associate's (QMHS): Practitioner Modifier HM
- QMHS – Bachelor's (QMHS): Practitioner Modifier HN
- QMHS – Master's (QMHS): Practitioner Modifier HO
- QMHS – 3 years' experience (QMHS): Practitioner Modifier UK
- Care Management Specialist – High School (CMS): Practitioner Modifier HM
- Care Management Specialist – Associate's (CMS): Practitioner Modifier HM
- Care Management Specialist – Bachelor's (CMS): Practitioner Modifier HN
- Care Management Specialist – Master's (CMS): Practitioner Modifier HO
- Peer Recovery Supporter – High School (PRS): Practitioner Modifier HM
- Peer Recovery Supporter – Associate's (PRS): Practitioner Modifier HM
- Peer Recovery Supporter – Bachelor's (PRS): Practitioner Modifier HN
- Peer Recovery Supporter – Master's (PRS): Practitioner Modifier HO

Covered Community Behavioral Health Services

*For additional information see Molina's PA Code Lists on the Provider website.
**For additional information see the ODM Medicaid Behavioral Health Manual.

- Assertive Community Treatment (ACT)*
  - Must be an ACT enrollee Covered.
- Intensive Home-Based Treatment (IHBT)*
  - Covered.
- SUD Partial Hospitalization*
  - Covered.
- Psychiatric Diagnostic Evaluations*
  - One encounter per person, per calendar year, per code, per billing agency.
- Psychological Testing*
  - Up to 20 hours/encounters per patient, per calendar year.
- Screening Brief Intervention and Referral to Treatment (SBIRT)*
  - One of each service, per billing agency, per patient, per year.
- Alcohol or Drug Assessment*
  - Two hours per patient, per calendar year, per billing agency.
  - Does not count toward ASAM level of care benefit limit.

- SUD Residential*
  - Up to 30 consecutive days of the first two stays are covered without authorization.
  - Medical Necessity for continued stay.
- Evaluation and Management Services/Home Visits (MH/SUD)**
  - Covered.
- Prolonged Visits (MH/SUD)**
  - Covered.
- Electrocardiogram (MH/SUD)**
  - Covered.
- Medication Administration by Medical Personnel (MH/SUD)**
  - Covered.
- Laboratory Services (MH/SUD)**
  - Covered.
- Vaccine Administration**
  - Covered.
- Psychotherapy for Crisis**
  - Covered.
- Individual/Family/Multiple-Family group Psychotherapy**
  - Covered.
- Interactive Complexity**
  - Covered.
- Individual/Group Therapeutic Behavioral Services (TBS)**
  - Covered.
- Nursing Services (Group or Individual)**
  - Covered.
- TBS Group Service (Day Treatment)**
  - Covered.
- Psychosocial Rehabilitation**
  - Covered.
- Community Psychiatric Supportive Treatment – Group**
  - Covered.
- Behavioral Health Counseling**
  - Covered.
- SUD Assessment**
  - Covered.
- SUD Individual and Group Peer Recovery Support**
  - Covered.
- Individual/Group Counseling**
  - Covered.
- SUD Care Management**
  - Covered.

- Urine Drug Screening – collection, handling and point of service testing**
  - Covered.
- Group Counseling IOP/PH- Level of Care**
  - Covered.
- Withdrawal Management**
  - Covered.
- Clinically Managed Low/High-Intensity Residential Treatment ASAM**
  - Covered.
- Clinically Managed Withdrawal Management ASAM**
  - Covered.
- Clinically Managed Population-Specific High Intensity Residential Treatment ASAM (Adults)**
  - Covered.
- Medically Monitored Intensive Inpatient Treatment (Adults/Adolescent)**
  - Covered.
- Medically Monitored Inpatient Withdrawal Management**
  - Covered.

Opioid Treatment Program (OTP)

All the OTP services must be performed by one of the following medical professionals within their scope of practice: physician, physician assistant, clinical nurse specialist, certified nurse practitioner, licensed practical nurse or a registered nurse.

Methadone Administration for Opioid Treatment Program:

- H0020
  - Must bill HF modifier for daily administration.
  - Will bill TV modifier for one week of take-home medication.
  - Will bill UB modifier for two weeks of take-home medication.
  - Will bill TS modifier for three weeks of take-home medication.
  - Will bill HG modifier for four weeks of take-home medication.
- 99211 and J2310
  - Combination only used when the naloxone is administered nasally on site.
- 96372 and J2310
  - Combination only used when naloxone is administered by injection on site.
- J8499
  - May bill for cost of oral naltrexone under Ohio Board of Pharmacy License.
- 36415
  - May bill for the collection of blood using venipuncture, per draw when sample is sent to an outside lab for testing.
- J2310

- May bill for cost of injectable or nasal naloxone when provided in accordance with ORC 4731.941 and under the Ohio Board of Pharmacy license and conformance requirements.

Buprenorphine Administration for Opioid Treatment Program:

- T1502
  - Must bill HF modifier for daily administration.
  - Will bill TV modifier for one week of take-home medication.
  - Will bill UB modifier for two weeks of take-home medication.
  - Will bill TS modifier for three weeks of take-home medication.
  - Will bill HG modifier for four weeks of take-home medication.
- 99211 and J2310
  - Combination only used when the naloxone is administered nasally on site.
- 96372 and J2310
  - Combination only used when naloxone is administered by injection on site.
- J8499
  - May bill for cost of oral naltrexone under Ohio Board of Pharmacy License.
- 36415
  - May bill for the collection of blood using venipuncture, per draw when sample is sent to an outside lab for testing.
- J2310
  - May bill for cost of injectable or nasal naloxone when provided in accordance with ORC 4731.941 and the Ohio Board of Pharmacy license and conformance requirements.
- J0571, J0572, J0573, J0574, J0575
  - Must bill appropriate J code for the buprenorphine-based medication that was administered.
- S5000 or S5001
  - May bill for take home doses for brand or generic w/HD modifier.

Respite Services for Children Enrolled in Managed Care

With the implementation of revised OAC 5160-26-03 Managed Health Care Programs: Covered Services, the eligibility criteria for children with long-term services and supports (MLTSS) needs has been updated. Behavioral health eligibility criteria was added to allow children with a severe emotional disturbance (SED) diagnosis to access respite services. Refer to OAC Rule 5160-26-03.2 for additional details regarding MLTSS respite services for children and OAC Rule 5160-59-03.4 OhioRISE: behavioral health respite services for children.

Eligibility

- MLTSS Criteria:
  - Under 21 years of age.

  - Reside with unpaid primary caregiver in a home.
  - Not a foster child.
  - Enrolled in the MCP Care Management Program.
  - Have MLTSS needs - as determined through an institutional level of care.
  - Require skilled nursing or skilled rehab at least once per week.
  - Determined eligible for SSI or SSDI.
  - MCP determination that child's caregiver has a need for temporary relief to prevent an out-of- home stay.
  - Had a need for at least 14 hours per week of home health aide services for two months prior.
- Behavioral Health Criteria
  - Under 21 years of age.
  - Reside with unpaid primary caregiver in a home.
  - Not a foster child.
  - Enrolled in the MCP Care Management Program.
  - Have behavioral health needs - as determined through a functional assessment.
  - Diagnosed with an SED as documented in the appendix to rule 5160-26-03.1.
  - Not exhibiting behaviors that indicate risk of harm to self or others.
  - MCP determination that child's caregiver has a need for temporary relief to prevent an out-of-home stay or due to history of out-of-home stays.

Respite Details

- Each child may receive up to 100 hours of respite services per calendar year.

Billing Codes

- S5151 Per Diem (For any respite services lasting beyond 12 hours of care.)
- S5150 per 15-minute unit.
- These codes will be used for both MLTSS and BH respite services. The Provider type will be used to differentiate between the two respite services.

Providers Requirements

- Provider Agencies
  - MLTSS
    - Medicaid enrolled.
    - Medicare-certified home health agencies or accredited by one of three entities.
    - Criminal records check in compliance with OAC rules 5160-45-07 and 5160-45-11.
  - Behavioral Health
    - Medicaid enrolled.
    - Ohio MHAS-certified and accredited by one of three entities.

    - Criminal records check in compliance with OAC rule 5160-43-09 when services are provided in an HCBS setting.

- Provider Agencies Employees
  - MLTSS
    - Obtain and maintain first aid certification.
    - Completion of competency evaluation program or training.
    - Supervised by an RN.
    - Completion of 12 hours in-service continuing education training.
  - Behavioral Health
    - Obtain and maintain first aid certification.
    - Credentialed by one of several Ohio boards or have received training/education in mental health competencies.
    - Supervised by an independently licensed BH professional credentialed by one of several Ohio boards.

Specialized Recovery Services (SRS) Program

Specialized Recovery Services Program (SRS) means the Home and Community-Based Services (HCBS) Program jointly administered by ODM and the Ohio Department of Mental Health and Addiction Services (ODMHAS) to provide services to individuals with qualifying diagnoses of severe and persistent mental illness or diagnosed chronic conditions.

Recovery Management

The recovery management service consists of a recovery manager working with an SRS eligible individual to develop an SRS person-centered care plan. A recovery manager will meet with individuals regularly to monitor their plan and the receipt of SRS under an individual's person-centered care plan. Recovery managers may also provide information and referrals to other services.

Individualized Placement and Support-Supported Employment (IPS-SE)

IPS-SE are activities that help individuals find a job if they are interested in working. An IPS-SE qualified worker will evaluate and consider an individual's interests, skills, experience and goals as it relates to employment goals. IPS-SE Programs also provide on-going support to help individuals successfully maintain employment.

Peer Recovery Support

Peer recovery support is provided by individuals who utilize their own experiences with mental health to help individuals identify and reach their recovery goals. Individualized recovery goals will be incorporated into the SRS person-centered care plan designed by the individual based on their preferences and the availability of community and natural supports. The peer

relationship can help individuals focus on strategies and progress toward self-determination, self-advocacy, well-being and independence.

C. March Vision Covered Services

March Vision will process and pay benefit eligible service codes regardless of diagnosis code when the Member is benefit eligible for the service code billed.

If March Vision receives a subsequent Claim for a benefit eligible service code where the Member's benefit has been exhausted, any Claims billed with a diagnosis code not found in the Refractive Diagnosis Code listing below will be processed with an indication to submit the Claim to the health plan.

March Vision will process Claim payment to optometrists, opticians and ophthalmologists.

Service Code					Refractive Diagnosis Code	
92002	G0118	V2205	V2314	V2718	H4420	Z0101
92004	S0580	V2206	V2315	V2730	H4421	Z01020
92012	S0620	V2207	V2318	V2744	H4422	Z01021
92014	S0621	V2208	V2319	V2745	H4423	
92015	V2020	V2209	V2320	V2750	H5200	
92071	V2025	V2210	V2321	V2755	H5201	
92072	V2100	V2211	V2399	V2756	H5202	
92310	V2101	V2212	V2410	V2760	H5203	
92311	V2102	V2213	V2430	V2761	H5210	
92312	V2103	V2214	V2499	V2762	H5211	
92313	V2104	V2215	V2500	V2770	H5212	
92314	V2105	V2218	V2501	V2780	H5213	
92315	V2106	V2219	V2502	V2781	H52201	
92316	V2107	V2220	V2503	V2782	H52202	
92317	V2108	V2221	V2510	V2783	H52203	
92325	V2109	V2299	V2511	V2784	H52209	
92326	V2110	V2300	V2512		H52211	
92340	V2111	V2301	V2513		H52212	
92341	V2112	V2302	V2520		H52213	
92342	V2113	V2303	V2521		H52219	
92352	V2114	V2304	V2522		H52221	
92353	V2115	V2305	V2523		H52222	
92354	V2118	V2306	V2530		H52223	
92355	V2121	V2307	V2531		H52229	

Service Code					Refractive Diagnosis Code	
92370	V2199	V2308	V2599		H5231	
92371	V2200	V2309	V2600		H5232	
V2106	V2201	V2310	V2700		H524	
V2220	V2202	V2311	V2702		H526	
V2522	V2203	V2312	V2710		H527	
G0117	V2204	V2313	V2715		Z0100	

D. Telehealth and Telemedicine Services

Provider shall comply with all operating policies and procedures adopted by Molina both for providing telehealth services, as described below, as well as taking into account all other areas of this manual that have implications for telehealth for MyCare Ohio and Medicaid lines of business, including:

- Benefits and Covered Services
- Claims and Compensation
- Compliance

Definitions Per OAC 5160-1-18 Telehealth

Telehealth is the direct delivery of health care services to a patient related to diagnosis, treatment, and management of a condition:

- Telehealth is the interaction with a patient via synchronous, interactive, real-time electronic communication that comprises both audio and video elements; or,
- The following activities that are asynchronous or do not have both audio and video elements:
  - Telephone calls;
  - Remote patient monitoring; and
  - Communication with a patient through secure electronic mail or a secure patient portal.
- For services rendered by behavioral health providers as defined in rule 5160-27-01 of the Administrative Code, telehealth is defined in rule 5122-29-31 of the Administrative Code.
- Conversations or electronic communication between practitioners regarding a patient without the patient present is not considered telehealth unless the service would allow billing for practitioner to practitioner communication in a non-telehealth setting.

The following terms are used for the locations utilized for real-time service via telecommunications.

Patient Site is the physical location of the patient at the time a health care service is provided through the use of telehealth. Locations include, but are not limited to:

- Home
- School

- Temporary housing
- Homeless shelter
- Nursing Facility
- Hospital
- Group home
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs)
- A Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)
- Assisted Living Facility
- Ambulatory Health Care Clinics

Practitioner Site is the physical location of the treating practitioner at the time a health care service is provided through the use of telehealth.

Note: Please reference the above OAC rule for listing of eligible providers.

Benefits

Payment may be made only for the following medically necessary health care services identified in Appendix A of the OAC Telehealth rule when delivered through the use of telehealth from the practitioner site:

- When provided by a patient centered medical home as defined in rule 5160-19-01 of the Administrative Code or behavioral health provider as defined in rule 5160-27-01 of the Administrative Code, evaluation and management of a new patient described as "office or other outpatient visit" with medical decision making not to exceed moderate complexity.
- Evaluation and management of an established patient described as "office or other outpatient visit" with medical decision making not to exceed moderate complexity.
- Inpatient or office consultation for a new or established patient when providing the same quality and timeliness of care to the patient other than by telehealth is not possible, as documented in the medical record.
- Mental health or substance use disorder services described as "psychiatric diagnostic evaluation" or "psychotherapy."
- Remote evaluation of recorded video or images submitted by an established patient.
- Virtual check-in by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient.
- Online digital evaluation and management service for an established patient.
- Remote patient monitoring.
- Audiology, speech-language pathology, physical therapy, and occupational therapy services, including services provided in the home health setting.
- Medical nutrition services.
- Lactation counseling provided by dietitians.
- Psychological and neuropsychological testing.
- Smoking and tobacco use cessation counseling.

- Developmental test administration.
- Limited or periodic oral evaluation.
- Hospice services.
- Private duty nursing services.
- State plan home health services.
- Dialysis related services.
- Services under the specialized recovery services (SRS) program as defined in rule 5160-43-01 of the Administrative Code.
- Notwithstanding paragraph (D)(2) of the above-referenced Telehealth rule, behavioral health services covered under Chapter 5160-27 of the Administrative Code.
- Optometry services.

Benefits are not provided for any technical equipment or costs for the provision of telemedicine services. The following are additional provisions that apply to the use of Telehealth and Telemedicine services:

- Services are a method of accessing Covered Services, and not a separate benefit
- Services are not permitted when the Member and participating Provider are in the same physical location (i.e. room or building)
- Services do not include texting or facsimile

Member Eligibility and Consent for Telehealth Services

Molina allows any Member to access telehealth services. There are not criteria for Member geography or physical proximity to Providers. Molina acknowledges that depending on a Member's situation, a Member may find additional convenience through telemedicine even if they live in area with many Providers located a short distance from their home.

Organizations and health professionals providing telehealth services shall ensure compliance with relevant legislation, regulations and accreditation requirements for supporting Member decision-making and consent.

Special Populations:

1. English as a second language – Provide and document use of interpreter.
2. Comply with the Americans with Disabilities Act of 1990 (ADA) and other legal and ethical requirements.
3. Pediatric – Encounters require the presence and/or active participation of a caregiver or facilitator, including the parent, guardian, nurse, and/or childcare worker. The practitioner shall obtain consent from the parent or legal representative of the child as required by law in the respective jurisdiction. With parental consent, it is acceptable for a minor to have a telehealth session alone without a caregiver or facilitator present in the same room.

   a. Abuse: In the evaluation of child abuse and/or sexual abuse, state child protective rules supersede individual Privacy and Family Educational Rights and Privacy Act (FERPA) regulations for consent.
      i. Images captured for the evaluation of child abuse and/or sexual abuse shall follow Store-and-Forward guidance for safety, security, privacy, storage and transmissions as well as institutional policies.
4. Homebound/Geriatric – Providers should have the patient affirm consent to family members, caregivers and nurses that would facilitate the visit and decision-making. If the patient is in a care facility or senior living community, a trained technician may assist in collecting relevant clinical information, including medical records, lab or diagnostic testing, and access to caregivers and staff. Providers should take into account the special needs of the elderly; and take these into account when designing and choosing technology configuration for telehealth equipment and systems.

The Member, or their guardian, need to have the option to consent to the use of telehealth for services, instead of in-person delivered care. This consent shall be documented and include:

a. Description so Member understands how telehealth service compares to in-person delivered care. Apprise Member of their rights when receiving telemedicine, including the right to suspend or refuse treatment.
b. Apprise Member of their own responsibilities when participating in telehealth.
c. Inform Member of a formal complaint or grievance process used to resolve ethical concerns or issues that might arise as a result of participating in telehealth.
d. Record keeping, the process by which Member information will be documented and stored.
e. Discuss the limits to confidentiality in electronic communication. Discuss the potential benefits, constraints and risks (e.g., privacy and security) of telehealth.
f. Go over potential risks, include an explicit emergency plan (particularly for Members in settings without access to clinical staff). The plan should include calling the Member via telephone and attempting to troubleshoot the issue together. It may also include referring the Member to another Provider or completing the encounter by voice only.
g. Credentials of the practitioner site Provider and billing arrangements. Information provided shall be in simple language that can easily be understood by the Member.
h. When going over potential for technical failure, a contingency plan is communicated to the Member in advance of the telehealth encounter.
i. Procedures for coordination of care with other professionals.
j. A protocol for contact between visits.
k. Prescribing policies including local and federal regulations and limitations.
l. Conditions under which telehealth services may be terminated and a referral made to in-person care.
m. Description of appropriate physical environment free from distractions, conducive for privacy, in proper lighting and minimizing background noise.

n. Inform Members and obtain the Member's consent when students or trainees observe the encounter.
o. Member shall consent in writing prior to any recording of the encounter.

Privacy and Security

Molina expects that 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). Please refer to the Compliance section of this Provider Manual for more information.

Provider Directory Listing

Molina offers a visual icon in our Provider Online Directory (POD) that indicates whether a Provider offers any telehealth services. Please notify your Provider Services Team as soon as possible if your organization adds telehealth capabilities, so we can update this data field and identify this option appropriately.

Claims and Billing

Providers must follow CMS guidelines as well as the Ohio telehealth billing guidelines.

Guidance for Medicaid as Primary Payer: The GT modifier, and any other appropriate modifiers, should be included on all telehealth claims and the POS should accurately reflect the physical location of the practitioner**.

*The only exception to this guidance is for Home Health Services, RN Assessment and RN Consultation. POS 02 should be used to indicate telehealth for the following codes: G0156, G0299, G0300, T1001, T1001 with U9 Modifier, G0151, G0152, G0153.

**Community behavioral health Providers should follow the guidance provided in the Ohio Department of Medicaid Behavioral Health Provider Manual.

Guidance for Medicare as Primary Payer: Use the telehealth POS Code 02, which certifies that the service meets the telehealth requirements. By coding and billing a POS 02 with a covered telehealth procedure code, the provider is certifying the member was present at an eligible originating site when the telehealth services were performed. Modifier GQ is required when applicable. Qualifying telehealth units of service for an originating site must be billed with Q3014 for reimbursement of facility fee.

Upon at least 10 days prior notice to Provider, Molina shall further have the right to a demonstration and testing of Provider telehealth service platform and operations. This demonstration may be conducted either virtually or face-to-face, as appropriate for telehealth

capabilities and according to the preference of Molina. Provider shall make its personnel reasonably available to answer questions from Molina regarding telehealth operations.

E. Medicaid Billing Guidelines

Advanced Practice Nurses (APN)

When billing for any service provided by an APN, all services must be billed with the appropriate modifier to denote the type of APN that provided the service:

- Bill the modifier "SA" e.g. 99201SA, if the APN is a nurse practitioner
- Bill the modifier "SB" e.g. 99201SB, if the APN is a nurse mid-wife
- Bill the modifier "UC" e.g. 99201UC if the APN is a clinical nurse specialist

APN services will be reimbursed, in accordance with OAC 5160-4-04 Advanced Practice Registered Nurses (APRN) Service, the lesser of the Provider's billed charge or one of the following:

- 85 percent of the Provider contracted rate when services are provided by an APN in the following places of service: inpatient hospital, outpatient hospital, or hospital emergency department
- 100 percent of the Provider contracted rate when services are provided by an APN in any non-hospital setting

Anesthesia Services

Molina requires all anesthesia services be billed with the number of actual minutes in the unit's field (item 24G) of the CMS-1500 form. The minutes will be calculated by 15-minute increments and rounded to the nearest tenth to determine the appropriate units to be paid. If the Claim is submitted without the minutes in field 24G, the Claim will be denied.

Anesthesia services will not be paid for surgeries that are non-covered.

Bilateral Surgery

Bilateral procedures performed – reference OAC 5160-4-22 Surgical Services for physician Claims.

Bilateral surgeries are procedures performed on both sides of the body at the same operative session or on the same day (two ears, two feet, two eyes, etc.).

Guidelines for bilateral procedures are as follows:

- The surgical procedure should be billed on a single line with modifier 50 and one unit.
- Modifier 50 should not be used to report:
  - Procedures that are bilateral by definition or their descriptions include the terminology such as "bilateral" or "unilateral".

- Dates of service prior to Aug. 1, 2017
  - Modifier 50 should not be used to report diagnostic and radiology facility services. Institutional Claims received for an outpatient radiology service appended with modifier 50 will be denied.
- Dates of service on or after Aug. 1, 2017
  - Modifier 50 is required for radiology unless the code is written as a bilateral procedure or service

Chronic Conditions

In order for Molina to accurately identify Members with chronic conditions that may be eligible for one of the Disease Management or Care Management Programs, please see the suggested billing tips listed below:

- For Members with chronic illness, always include appropriate chronic and disability diagnoses on all Claims.
- Document chronic disease (please note, Molina has identified asthma as the most common diagnosis code not reported) whenever it is appropriate to do so. This includes appointments when prescription refills are written for chronic conditions.
- Be specific on diagnosis coding; always use the most specific appropriate diagnosis code available.

Diagnosis Pointers

A single encounter may frequently correlate with multiple procedures and/or diagnosis codes. Diagnosis pointers are required if at least one diagnosis code appears on the Claim and must be present with the line item with which it is associated. This is a single digit field used to "point" to the most appropriate ICD-10 codes by linking the corresponding diagnosis reference number (1, 2, 3, and/or 4) from the diagnosis indicated in item number 21. Do not enter the actual ICD-10 codes or narratives in item number 21.

A pointer should be submitted to the Claim diagnosis code in the order of importance. The remaining diagnosis pointers are used in declining level of importance to the service line. Please reference the appropriate ODM Companion Guide (837P), found on the ODM website at medicaid.ohio.gov/, for the appropriate loop and segments.

Dialysis Services

Molina requires one service line per date of service with a maximum unit of one for dialysis services. If a Claim is received with a date span billing multiple units on a single charge line, the charge line will be denied.

Durable Medical Equipment

Molina follows the DME guidelines as referenced in the ODM Supply List and the Orthotic and Prosthetic List. It is imperative that appropriate billing be used to identify the services provided and process Claims accurately.

- 5160-10-01 Appendix – Medicaid Supply List

Molina follows the indicators published on the ODM Medicaid Supply List listed below:

- "Max Units" indicator – A maximum allowable (MAX) indicator means the maximum quantity of the item that may be reimbursed during the time period specified, unless an additional quantity has been prior authorized. If there is no maximum quantity indicated, the quantity authorized will be based on Medical Necessity as determined by Molina.
- "RNT/P" indicator
  - "RO" means item is always rented – A DME code with this indicator should be billed with the RR modifier for the applicable rental period.
  - "PP" means item is always purchased – A DME code with this indicator should NOT be billed with a modifier.
  - "R/P" means item is designated as rent to purchase as described in OAC 5160-10-01 Medical Supplies, Durable Medical Equipment, Orthoses, and Prosthesis Providers – A DME code with this indicator MUST be billed with a modifier.

Claims payment on rent to purchase DME codes billed without the NU modifier will be paid as a monthly rental. This change will ensure monthly rental DME items are reimbursed as such and reduce your administrative work to post recoveries.

Durable Medical Equipment (DME), Medical Supplies and Parenteral Nutrition

Molina billing requirements are:

- Submit one service line per each date of service
- Use the shipping date as the date of service on the Claim if a shipping service or mail order is utilized
- Always include the appropriate modifier on all DME Claims for rent to purchase items listed in the Ohio Medicaid Supply List
  - RR modifier is required when item is rented
  - NU modifier is required when item is purchased

Emergency Room Evaluation and Management with Modifier 25

When circumstances warrant the billing of a modifier 25 for physician Claims that include an Emergency Room Evaluation and Management code (ER E/M) when billed with a surgical procedure code, Molina requires medical records with the initial Claim submission.

Enteral Nutrition Formula – B Code Products

Molina billing requirements are:

- 1 unit = 100 calories (calories/100)

- 11-digit NDC number must be present on Claim
- Submit one service line per each date of service
- Use the shipping date as the date of service on the Claim if a shipping service or mail order is utilized

Please see the below examples and refer to the ODM supply list and OAC 5160-10-01 Medical Supplies, Durable Medical Equipment, Orthoses, and Prosthesis Providers for further details.

Example: B4220 – PARENTERAL NUTRITIONAL SUPPLY KIT; PREMIX, COMPLETE – PER DAY 1/DAY PP

- Incorrect billing with a date span:
  - DOS: 11/28/10-11/30/10
  - Service Code: B4220
  - Billed Charges: $60.00
  - Units: 3

- Appropriate billing is equal to the shipping date:
  - DOS: 11/28/10-11/28/10
  - Service Code: B4220
  - Billed Charges: $60.00
  - Units: 3

Example: E0565 - COMPRESSOR, AIR POWER SOURCE FOR EQUIPMENT NOT SELF-CONTAINED OR CYLINDER - EACH 1/4 YRS R/P

- DOS: 11/28/10-11/28/10
  - Service Code: E0565
  - Modifier: RR
  - Billed Charges: $100.00
  - Units: 1 (1st month rental)

- DOS: 12/28/10-12/28/10
  - Service Code: E0565
  - Modifier: RR
  - Billed Charges: $100.00
  - Units: 1 (2nd month rental)

- DOS: 01/28/11-01/28/11
  - Service Code: E0565
  - Modifier: RR
  - Billed Charges: $100.00
  - Units: 1 (3rd month rental)

- DOS: 02/28/11-02/28/11
  - Service Code: E0565
  - Modifier: NU
  - Billed Charges: $600.00
  - Units: 1 (purchased)

Example: B4160 - PEDIASURE LIQUID VANILLA (NDC # 70074-0558-98) for 29,900 calories

- DOS: 11/28/10-11/28/10
  - Service Code: B4160
  - Billed Charges: $450.00
  - Units (Calorie units): 299

Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) Healthchek Services/Family Planning

Healthchek is Ohio's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. It is a service package for babies, kids, and individuals younger than 21 who are enrolled in Ohio Medicaid. Additional information can be found on the ODM website at medicaid.ohio.gov.

Please refer to the ICD-10-CM Code Tables located on the Centers for Medicare and Medicaid Services (CMS) Website for EPSDT CPT Codes: cms.gov.

Providers can request prior authorization to exceed any service that reflects coverage and/or benefit limitations for Members under age 21.

Prior authorizations/coverage determinations must be reviewed for Medical Necessity as defined in OAC 5160-1-01(A).

NOTE: CPT codes must be used in conjunction with diagnosis:
- Encounter for health supervision and care of infant, child or foundling
- Encounter for health supervision and care of other healthy infant and child
- Encounter for routine child health examination with normal or abnormal findings
- Encounter for general adult medical examination with normal or abnormal findings
- Encounter for examination for admission to educational institution or residential institution, for sports, driver's license, insurance, adoption, or other administrative purposes
- Encounter for paternity testing, blood alcohol or blood drug tests, or other exam and observation for medico-legal reasons
- Encounter for other general examination
- Encounter for examination for normal comparison and control in clinical research program
- Encounter for examination of potential donor of organ and tissue
- Encounter for examination for period of delayed growth in childhood with or without abnormal findings

EPSDT Claims

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.

Per ODM Billing Guide for Institutional Claims, the referral field indicator should be reported in field 24H for Healthchek/EPSDT services as follows:

Lower, Unshaded Area

- Enter 'E' in the lower, unshaded area in field 24H if the service was related to Healthchek (EPSDT).
- Enter 'F' in the lower, unshaded area in field 24H if the service was related to family planning.
- Enter 'B' in the lower, unshaded area in field 24H if the service was related to both Healthchek (EPSDT) and family planning.

Upper, Shaded Area

- If either E or B is entered in the lower, unshaded area, then add the appropriate condition indicator in the upper, shaded area in field 24H using one of the following:
  - NU (No Healthchek (EPSDT) referral was given)
  - AV (Referral was offered, but the individual refused it)
  - ST (New services requested)
  - S2 (Under treatment)

Electronic Claims

Per ODM 837 Health Care Claim Professional Companion Guide, completion of CRC02 and CRC03 are required for electronic Claims.

Select the appropriate response in Loop 2300 Segment CRC02, "Was an EPSDT referral given to the patient?" as follows:

- Enter 'Y' in Loop 2300, Segment CRC02 if the service was Healthchek and follow-up is required, and a referral is made.
- Enter 'N' in Loop 2300, Segment CRC02 if the service is a Healthchek and no follow-up services were required.

Select the appropriate condition indicators in Loop 2300, Segment CRC03.

- If response to CRC02 is Yes, use one of the following in Loop 2400, Segment SV111:
  - AV (Referral was offered, but the individual refused it)
  - ST (New services requested)
  - S2 (Under treatment)

- If response to CRC02 is No, use the following:
  - NU (No Healthchek (EPSDT) referral was given)

Enter 'Y' in Loop 2400, Segment SV112 if the service involved family planning.

For additional information, please reference the appropriate ODM Companion Guide (837P) found on the ODM website at medicaid.ohio.gov.

Billing for Preventive and Sick Visits on the Same Date of Service

Did you know Molina will pay for both a new/established patient preventative/well visit with a new/established patient sick visit for the same Member on the same date of service if the diagnosis codes billed support payment of both codes? Be sure to bill the correct diagnosis codes and bill the new/established patient E&M with modifier 25 to ensure accurate payment. Please note that medical documentation is not needed with modifier 25.

Home Health Services

- Per OAC 5160-12-01 Home Health Services: Provision Requirements, Coverage and Service Specification, a face-to-face encounter with the qualifying treating physician must be done within 90 days prior to start of care or within 30 days following the start of care. The treating physician must complete a Certificate of Medical Necessity, Form JFS 07137, documenting this visit and the reasons for requesting home care.
- The Provider must have the Certificate of Medical Necessity on the appropriate JFS 07137 form on file and available for review upon request.
- Home health services may be provided outside of the individual's place of residence, in any setting in which normal life activities take place, other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Home Health Services for Member and Baby after Delivery

HQ modifier must be appended to both Member and baby's Claim, indicating a group visit.

Pursuant to OAC 5160-12-05 Reimbursement: Home Health Services, the amount of reimbursement for each visit shall be the lesser of the Provider's billed charge or 75 percent of the Provider's contracted rate when billing with the modifier HQ "group setting" for group visits conducted in accordance with OAC 5160-12-04 Home Health and Private Duty Nursing: Visit Policy.

Respite Care Services

Respite care is the provision of short-term, temporary relief to those who are caring for family members who might otherwise require permanent placement in a facility outside the home.

The service provides general supervision, meal preparation and hands-on assistance with personal care that are incidental to supervision during the period of service delivery. Respite services can be provided on a planned or emergency basis and shall only be furnished at the primary place of residence. The Provider of respite care must be awake during the provision of respite services and the services shall not be provided overnight.

- Respite services are limited to no more than 100 hours per year per Member.
- Respite services **must** be provided by enrolled Medicaid Providers who meet the qualifications of the program, including a competency evaluation program and first-aid training. Respite services must not be delivered by the child's legally responsible family member or foster caregiver. (OAC 5160-26-3 Managed Health Care Programs: Covered Services)

All the following criteria are required to be met in order to qualify for the benefit:

- The Member must reside with their informal, unpaid primary caregiver in a home or an apartment that is not owned, leased or controlled by a Provider of any health-related treatment or support services.
- The Member must not be residing in foster care.
- The Member must be under age 21 and determined eligible for Social Security income for children with disabilities or supplemental security disability income for adults disabled since childhood.
- The Member must be enrolled in the MCP's Care Management Program.
- The Member must be determined by the MCP to meet an institutional level of care as set forth in 5160-3-08 Criteria for Nursing Facility-Based Level of Care.
- The Member must require skilled nursing or skilled rehabilitation services at least once per week.
- The Member must have received at least 14 hours per week of home health aide services for at least two consecutive months immediately preceding the date respite services are requested.
- The MCP must have determined that the child's primary caregiver has a need for temporary relief from the care of the child as a result of the child's long-term services and support needs/disabilities, or in order to prevent the provision of institution or out-of-home placement or:
    - Have behavioral health needs as determined by the MCP through the use of a nationally recognized standardized functional assessment tool, and
        - Be diagnosed with serious emotional disturbance as described in the appendix to this rule resulting in a functional impairment,
        - Not be exhibiting symptoms or behaviors that indicate imminent risk of harm to themselves or others.

HCPC G0156 will be the code used to bill for respite services and will require the GY modifier in addition.

Other Modifiers that can be used in addition to GY for respite care services

- U2 – Second Visit – Must be used to identify the second visit for the same type of service made by the same Provider on the same date of service per Member.
- U3 – Third Visit or more – Must be used to identify the third or more visit for the same type of service made by the same Provider on the same date of service per Member
- HQ – Group Visit – Indicates that a group visit was done

Inpatient Emergency Room (ER) Admissions

Molina requires medical records with the initial Claim submission. This is required so the Claim can be reviewed for an inpatient authorization if an authorization is not on file due to the emergency situation.

Interim Claims – Type of Bill (TOB) 112, 113, and 114

Upon discharge of a Molina Member, the inpatient hospital Claim should be submitted with the complete confinement on a Claim with TOB 111 if interim Claims were previously processed. Molina requires a Claim with the complete confinement to ensure accurate Claims payment.

Locum Tenens Services Substituting for an Absent Provider

A Molina contracted Provider may arrange for a temporary replacement to provide services to their patients as an independent contractor for a limited time due to an illness, a pregnancy, vacation, etc. This is known as a locum tenens arrangement.

Billing and Documentation Requirements

- Provider's office must keep a record of each service provided by the locum tenens Provider.
- Claims submitted for locum tenens services performed within the approved timeframe, not to exceed 60 days, should be billed with the locum tenens name in field 31 and NPI in field 24J of the CMS-1500 Claim form.
- Do not bill with the absent Provider's information as the rendering Provider.
- The tax identification number in field 25 and the NPI in field 33A should be billed with the absent Provider's office or group practice information. Modifier Q6 is not required.
- The payment will be made to the absent Provider's office or group practice at the contracted rate. It is assumed that the locum tenens physician will be compensated by the regular physician on a per diem or similar fee for time basis.

Locum Tenens Provider Requirements

- Sixty (60) days is the maximum timeframe allowed per Provider, per leave of absence.

- Claims should be submitted by the absent Provider's office or group practice and that office receives payment.
- Must be a Medicaid participating Provider.
- Must submit an attachment to Molina with locum tenens Provider information prior to seeing Molina Members each time the Provider will be substituting for a Molina participating Provider.
- Modifier Q6 is not required to be billed to identify arrangement.
- May be employed by the same group as the regular/absent Provider, but not required.

Maternity Care

Last menstrual period (LMP) date requirement: In accordance with OAC 5160-26-06 Managed Health Care Programs: Program Integrity – Fraud and Abuse, Audits, Reporting and Record Retention, Molina requires the LMP date on pregnancy-related services billed on a CMS-1500. Claims received with the following perinatal and/or delivery CPT code(s) must include an LMP date and meet the required date range specified below. Facility Claims billed on a UB-04 Claim form are excluded from the LMP requirement.

- **Delivery CPT Codes:**
  - LMP date must meet the required date range of the 119 to 315 days prior to the delivery DOS for the following codes: 59400, 59510, 59610, 59618
  - NOTE: If the LMP date field is left blank or falls outside of the 119 and 315 days, the entire Claim will be denied.
- **Perinatal CPT Codes:**
  - LMP date **must** meet the required date range of 1 to 315 days prior to the "to date" of the perinatal DOS for the following codes: 59425, 59426, 76801, 76802, 76805, 76810, 76811, 76812, 76815, 76816, 76818, and 80055
  - NOTE: If the LMP date field is left blank or falls outside of the 1 and 315 days, the entire Claim will be denied.

Molina realizes this information may not always be available to a radiologist or laboratory, particularly for services not performed face-to-face with the Member or the Provider who delivers the baby, especially if the Member received prenatal care from another Provider/facility. To avoid any unnecessary Claim denials, radiologists and laboratories must assure the written order or requisition from the treating practitioner includes an LMP date, when applicable. Please remember, participating Providers may estimate the LMP date on delivery Claims based on the gestational age of the child at birth.

CMS-1500

- The LMP should be reported as Item 10a-c – Patient's Condition – Check "YES" or "NO" to indicate whether employment, auto, or other accident involvement applies to one or more of the services described in Item 24.
- Item 14 – Enter the six-digit (MMDDYY) or eight-digit (MMDDCCYY) date of the LMP.

For EDI Claims, please reference the appropriate ODM Companion Guide (837P/837I), found on the ODM Trading Partner website at medicaid.ohio.gov for the appropriate loop and segments.

Molina will reimburse Providers for a prenatal risk assessment (PRA) by billing HCPCS code H1000 and completing the appropriate PRA form. The PRA form is a checklist of medical and social factors used as a guideline to determine when a patient is at risk of a preterm birth or poor pregnancy outcome. Both the Molina Healthcare PRA form and ODM 10207 PRA form will be accepted. The PRA form must be completed on each obstetrical patient during the initial antepartum visit in order to bill for the prenatal at-risk assessment code.

Forms are available at MolinaHealthcare.com/OhioProviders.

Providers may submit the PRA form to ODM at NurtureOhio.com. For additional information go to medicaid.ohio.gov and under the "Provider" tab select "Online Pregnancy Risk Assessment and Notification System (PRAF 2.0)."

Child Birth Delivery Procedures and ICD-10 Diagnosis Codes Required on Claims for Mother's Weeks of Gestation of Pregnancy

Effective March 1, 2017, Providers must include one of the ICD-10 diagnosis codes indicating the mother's weeks of gestation on Claims submitted to the Ohio Department of Medicaid (ODM) and Medicaid Managed Care (MCP) plans. This will be effective for Claims processed on or after March 1, 2017, and is based on date processed, not on the date of service.

ICD-10 Diagnosis Codes

- Z3A.00: Gestation not specified
- Z3A.01: Less than 8 weeks Gestation of Pregnancy
- Z3A.08: 8 weeks gestation of pregnancy
- Z3A.09: 9 weeks gestation of pregnancy
- Z3A.10: 10 weeks gestation of pregnancy
- Z3A.11: 11 weeks gestation of pregnancy
- Z3A.12: 12 weeks gestation of pregnancy
- Z3A.13: 13 weeks gestation of pregnancy
- Z3A.14: 14 weeks gestation of pregnancy
- Z3A.15: 15 weeks gestation of pregnancy
- Z3A.16: 16 weeks gestation of pregnancy
- Z3A.17: 17 weeks gestation of pregnancy
- Z3A.18: 18 weeks gestation of pregnancy
- Z3A.19: 19 weeks gestation of pregnancy
- Z3A.20: 20 weeks gestation of pregnancy
- Z3A.21: 21 weeks gestation of pregnancy
- Z3A.22: 22 Weeks gestation of pregnancy

- Z3A.23: 23 Weeks gestation of pregnancy
- Z3A.24: 24 Weeks gestation of pregnancy
- Z3A.25: 25 Weeks gestation of pregnancy
- Z3A.26: 26 Weeks gestation of pregnancy
- Z3A.27: 27 Weeks gestation of pregnancy
- Z3A.28: 28 Weeks gestation of pregnancy
- Z3A.29: 29 Weeks gestation of pregnancy
- Z3A.30: 30 Weeks gestation of pregnancy
- Z3A.31: 31 Weeks gestation of pregnancy
- Z3A.32: 32 Weeks gestation of pregnancy
- Z3A.33: 33 Weeks gestation of pregnancy
- Z3A.34: 34 Weeks gestation of pregnancy
- Z3A.35: 35 Weeks gestation of pregnancy
- Z3A.36: 36 Weeks gestation of pregnancy
- Z3A.37: 37 Weeks gestation of pregnancy
- Z3A.38: 38 Weeks gestation of pregnancy
- Z3A.39: 39 Weeks gestation of pregnancy
- Z3A.40: 40 Weeks gestation of pregnancy
- Z3A.41: 41 Weeks gestation of pregnancy
- Z3A.42: 42 Weeks gestation of pregnancy
- Z3A.49: Greater than 42 weeks Gestation of Pregnancy

On professional Claims, the current procedural terminology (CPT) codes must be tied to an ICD-10 diagnosis code. Diagnosis code validation edits allow four diagnoses pointers per detailed service line. If weeks of gestation codes are missing on the delivery detail of the Claim, the delivery service line will deny.

On hospital Claims, the weeks of gestation codes are not tied to the delivery procedure codes but are required on childbirth delivery Claims. If the weeks of gestation codes are missing from the inpatient Claim, the entire Claim will deny. If they're missing from the outpatient Claim, the delivery and all services provided on the same date as the delivery will deny.

Well Care through the Perinatal Period

Consider providing an annual well exam for your patients in addition to prenatal or postpartum care. The services required for a well exam (health and developmental history, both physical and mental, a physical exam, and health education/anticipatory guidance) are often provided as part of the prenatal or postpartum exam but may not have been coded in the past.

- Preventive services may be rendered on visits other than specific well care visits, regardless of the primary intent of the visit.
- Well visit and postpartum visit can be paid for the same office visit, provided that the appropriate procedure and diagnosis codes are included for both services.

To ensure accurate encounter reporting for HEDIS® and ODM requirements, the following ICD-10 codes should not be billed for a *non-delivery* event.

- **ICD-10 Diagnosis Codes**
  - Z39: Postpartum care and examination immediately after delivery
  - Z37.x: Outcome of delivery
  - O80: Encounter for full-term uncomplicated delivery

Or

- **CPT Codes:**
  - 59400-59410: Vaginal delivery, antepartum and postpartum care
  - 59510-59515: Cesarean delivery
  - 59610-59622: Delivery after previous cesarean delivery

Newborn Claims

Molina requires Providers to report the birth weight on all newborn institutional Claims. To report this data, the appropriate value code must be used:

- UB-04: Report in block 39, 40 or 41 using value code "54" and the newborn's birth weight, in grams. Please note: Providers should include decimal points when reporting birth weight. For example, if the birth weight is 1,000 grams, then the Provider should report 1000.00 along with value code 54.

- 837: Report birth weight as a monetary amount. Reference the appropriate ODM Companion Guide (837I), found on the ODM Trading Partner website at medicaid.ohio.gov, for the appropriate loop and segments.

Obstetrical Care

Molina is committed to promoting primary preventive care for Members. In an effort to ensure that female Members receive all needed preventive care, Molina encourages OB/GYNs to provide preventive care services in conjunction with obstetrical/gynecological visits.

When providing care to Molina Members, consider performing an annual well exam in addition to obstetric/gynecological services.

Services required during a well exam that should be documented in the medical record are:

- A health and developmental history (physical and mental)
- A physical exam
- Health education/anticipatory guidance

Note that:

- Preventive services may be rendered on visits other than well care visits, regardless of the primary intent of the visit.
- The appropriate diagnosis and procedure codes must be billed to support each service.
- A well exam and an ill visit can be paid for the same office visit, provided that the appropriate procedure and diagnosis codes are included for both services.

Coding for Well Care Services with Obstetric/Gynecological Services

Well Care Visit:

- Adolescent/adult preventative and well care visits (12 to 39 years)
  - CPT: 99384-99385, 99394-99395
  - ICD-10: Z00.00, Z00.01, Z02.2, Z02.4, Z02.5, Z02.6, Z02.82, Z02.89
- Obstetric/gynecological well care visits
  - CPT: 99201-99205, 99211-99215, 99241-99245
  - ICD-10: O44.00, O44.01, O44.02, O44.03, O44.21, O44.22, O44.23, O44.41, O44.43, O10.019, O10.919, O210.0, O47.00, O47.9, O48.1 O31.02X0, O98.13, O24.019, O99.210, O30.009, O32.0XX0, O33.0, O34.00, O35.0xx, O43.019, Z34.00

Sterilization/Delivery Services

Pursuant to OAC 5160-21-02.2 Medicaid Covered Reproductive Health Services: Permanent Contraception/Sterilization Services and Hysterectomy, Claims received for sterilization services are paid only if the required criteria are met and the appropriate Consent for Sterilization Form (HHS-687) has been received per the OAC. In addition, reimbursement will not be made for associated services such as anesthesia, laboratory tests, or hospital services if the sterilization service itself cannot be reimbursed. However, sterilization Claims received without a valid consent form attached that includes services unrelated to the sterilization i.e., delivery services, will be processed as follows:

- Inpatient hospital Claims on a UB-04 will be denied.
  - Reimbursement can be made for charges unrelated to the sterilization procedure when a corrected Claim is received, removing all of the sterilization related charges and ICD-10 diagnosis/procedure codes.
- Outpatient hospital Claims on a UB-04 will be denied.
- Physician services on the HCFA-1500 Claim form will deny the line items for the sterilization services and process the line items unrelated to the sterilization services for payment.
  - No corrected Claim form is required.

Consent to Sterilization Form is available at MolinaHealthcare.com/OhioProviders or on the ODM website.

Guidelines for Completing

CONSENT TO STERILIZATION FORM

HHS-687 (10/12)

Providers: Complete all fields unless optional is indicated. View the Consent to Sterilization Form provided at MolinaHealthcare.com/OhioProviders.

Consent to Sterilization

1. Doctor or Clinic – Name of physician or clinic providing the patient with the form.
2. Specify Type of Operation – List the name of the surgical procedure to be performed (e.g. tubal ligation, Essure®, bilateral partial salpingectomy (BPS), tubal occlusion, vasectomy, etc.). Must match the other "specify type of operation" field in the left column and the "specify type of operation" field under the Statement of Person Obtaining Consent.
3. Date – Patient's date of birth.
4. Name of Individual – Patient's first and last name.
5. Doctor or Clinic – Name of physician who will be performing the surgical procedure.
6. Signature – Patient's signature.
7. Date – Date patient signed consent form (must match the signature date of the Person Obtaining Consent). We do not and cannot accept date stamps.
   a. **Note:** The procedure cannot be performed until a full 30 days after this date and must be performed within 180 days of this date.
8. Optional – Patient can check the box of giving their race and ethnicity.

Statement of Person Obtaining Consent

1. Name of Individual – Patient's first and last name.
2. Specify Type of Operation – List the name of the surgical procedure to be performed (e.g. tubal ligation, Essure®, BPS, tubal occlusion, vasectomy, etc.). Must match the other "specify type of operation" field in the left column and the "specify type of operation" field under the Statement of Person Obtaining Consent.
3. Signature of Person Obtaining Consent – Physician or physician representative must sign. We do not and cannot accept signature stamps.
4. Date – Date consent was obtained (must match the signature date of the patient). We do not and cannot accept date stamps.
5. Facility – List the name of the doctor or clinic where the Person Obtaining Consent is located.
6. Address – List the facility's complete address (including city, state and zip code).

Physician's Statement

1. Name of Individual – Patient's first and last name.
2. Date of Sterilization – Date the surgical procedure was performed.

3. Specify Type of Operation – List the surgical procedure that was actually performed. It does not have to match the other three areas (e.g. tubal ligation, Essure®, BPS, tubal occlusion, vasectomy, etc.).
4. Paragraph 1 or 2 – Per instructions, "Cross out the paragraph which is not used."
   a. If paragraph 2 is selected, one of the following boxes must be checked:
      i. Premature delivery – indicate the expected date of delivery.
      ii. Emergency abdominal surgery – describe circumstances.
   b. Keep in mind that an individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since they gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least a full 30 days before the expected date of delivery.
5. Physician's Signature – Must be the physician who is performing or performed the surgery. This must be the physician's actual signature. We do not and cannot accept signature stamps.
6. Date – Date the physician signs. We do not and cannot accept date stamps.

**Note: Member's first and last name must match Molina of Ohio's system in order for the consent form to be approved. If the Member's name does not match our records, please advise the Member to update their name with their County Department of Job and Family Services (CDJFS) Case Worker.

For additional information on sterilization services or information for hysterectomy services, please refer to the Medicaid Benefits Index section of this appendix.

National Drug Codes (NDC)

NDCs are codes assigned to each drug package. Each NDC is an 11-digit number, sometimes including dashes in the format (e.g. 55555-4444-22). They specifically identify the manufacturer, product and package size.

In accordance with ODM payment policy, a valid 11-digit NDC number is required to be billed at the detail level when a Claim is submitted with a CPT/HCPCS code that represents a drug. Federal law requires that any code for a drug covered by Medicaid must be submitted with the NDC. The following codes require an NDC number:

- HCPCS J0120-J9999
- HCPCS Q0138-Q0139
- HCPCS Q0515
- HCPCS Q2009-Q2010
- HCPCS Q2017
- HCPCS Q2026-Q2027
- HCPCS Q2050
- HCPCS Q3025

- HCPCS Q4081
- HCPCS Q4096-Q4099
- HCPCS S0145
- HCPCS S0148
- HCPCS S0166
- HCPCS B4150-B4162
- CPT codes in the 90281-90399 series
- HCPCS B4164-B4216
- HCPCS B4220-B4224
- HCPCS B4240

NDC numbers must meet the following requirements:
- A valid/active 11-digit NDC number
- When the package of a drug only includes a 10-digit NDC number, the 10 digits must be converted to 11 digits by adding a leading zero to only one segment.
- Reported without dashes or spaces

If the NDC information is missing or invalid, the Claim line(s) will be denied.

When the package of a drug only includes a 10-digit NDC number, the 10 digits must be converted to 11 digits by adding a leading zero to only one segment as indicated below.
- If the first segment contains only four digits, add a leading zero to the segment
- If the second segment contains only three digits, add a leading zero to the segment
- If the third segment contains only one digit, add a leading zero to the segment

This applies to the following Claim types:
- CMS-1500 – Professional Claims
- UB-04 **–** All outpatient facility Claims including End-Stage Renal Disease Clinic Claims (bill type 13X and 72X)

Electronic Claims

For EDI Claims, please reference the appropriate ODM Companion Guide (837I/837P), found on the ODM Trading Partner website at medicaid.ohio.gov for the appropriate loop and segments to report the following:
- Qualifier of 'N4'
- 11-digit NDC number (do not enter hyphens or spaces with the NDC)
- Unit quantity
- Unit of measurement qualifier
  - F2 (International Unit)
  - GR (Gram)
  - ML (Milliliter)

- UN (Unit)

National Provider Identification Number (NPI)

Molina requires all Claims and encounters include an NPI in all Claim fields that require Provider identification, as provided below, to avoid any unnecessary Claim rejections.

- In accordance with 5010 requirements, NPIs are mandated on all electronic transactions per HIPAA.

The use of an NPI on paper Claims is a Molina requirement.

If you do not have an NPI, please visit nppes.cms.hhs.gov to obtain an NPI. Any changes to an NPI should also be reported to Molina within 30 days of the change.

NPI Required Fields: CMS-1500	Required?	Field Location
Billing Provider NPI	Yes	Box 33a
Rendering Provider NPI	Yes	Box 24j
Referring Provider NPI	If Applicable	Box 17b
Facility Provider NPI	If Applicable	Box 32a

NPI Required Fields: UB-04	Required?	Field Location
Billing Provider NPI	Yes	Box 56
Attending Provider NPI	If Applicable	Box 76
Operating Provider NPI	If Applicable	Box 77
Other Provider NPI	If Applicable	Box 78
Other Provider NPI	If Applicable	Box 79

Molina recommends all Providers reference the appropriate ODM Companion Guide (837I, 837P) found on the ODM Trading Partner website at medicaid.ohio.gov, for the appropriate loop and segments to ensure all 5010 requirements are being met.

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

Outpatient Hospital Services

In accordance with OAC 5160-2-75 Outpatient Hospital Reimbursement, additional payment will be made for dates of service on or after March 31, 2010 for the following:

- Stand-alone revenue codes billed with IV therapy
  - Line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) when the Claim carries IV therapy CPT code 96365, 96366, 96367, or 96368 that does not include dialysis, chemotherapy, or surgical services.
- Independently billed pharmacy or medical supplies
  - Line items that carry revenue center code 025X (with no CPT code present), 0636 (with a valid HCPCS J code) and/or revenue center code 027X (with no CPT code present) that does not include dialysis, chemotherapy, surgical, clinic, emergency room, radiology, ancillary, laboratory, or pregnancy related services.

Payment Policy for Services without a Published Reimbursement Rate

Reimbursement for services that are listed without a published rate in the Medicaid Fee Schedule appendices or specified as set forth in an OAC and deemed Medically Necessary, is made in accordance with the Provider contract. When the contract is silent, the payment amount is based on the default 30 percent of the billed charge. Providers must bill their usual and customary charge.

See OAC 5160-2-75 Outpatient Hospital Reimbursement for a list of procedure codes that were deemed inpatient only by the Centers for Medicare and Medicaid Services (CMS) and removed from Appendix C.

Interpreters Statement (Optional)

1. Optional – The interpreter defines the language used in the interpretation.
2. Optional – The interpreter signs their name.
3. Optional – The interpreter enters the date they read the statement to the patient.

Surgical Professional Services

In accordance with OAC 5160-4-22 Surgical Services, physicians must bill using the most comprehensive surgical procedure code(s). This means on Claims, Providers should report comprehensive surgical services; they are not to itemize or “unbundle” individual components.

Surgical codes subject to multiple surgery pricing are indicated in OAC 5160-4-22 Surgical Services - Appendix. Multiple surgery pricing will apply to the procedures indicated with an "x" in the corresponding column titled “Multiple Surgery” when multiple surgical procedures are performed on the same patient by the same Provider on the same day. These codes should not be billed with multiple units. Billing with more than one unit will result in a denial of that line.

Reimbursement guidelines for surgical codes subject to multiple surgery reduction are as follows:

- 100 percent of the contracted allowable rate for the primary procedure (highest allowable)
- 50 percent of the contracted allowable rate for the secondary procedure
- 25 percent of the contracted allowable rate allowed for all subsequent procedures

Effective July 1, 2017, co-surgery procedures, for which payment is split among two surgeons when performed on a surgical procedure that requires the skill of two surgeons will be reimbursed at 62.5 percent per surgeon of the Medicaid maximum amount specified in rule OAC 5160-1-60 Medicaid Payment or in appendix DD to that rule.

Effective Jan. 1, 2017, assistant-at-surgery services performed by Physician Assistants or Advanced Practice Nurses are reimbursed when billed with modifier AS at the lesser of the billed charge or 25 percent of the Medicaid maximum for the covered primary surgical procedure.

Transplants

In accordance with OAC 5160-2-03 Conditions and Limitations, services related to covered organ donations are reimbursable when the recipient of a transplant is Medicaid-eligible.

Transplant services will be reimbursed according to OAC 5160-2-05 Classification of Hospitals.

In order to receive reimbursement for organ acquisition charges, the following guidelines are applied:

- The charges must be reported using revenue center code "810 - Organ Acquisition, General Classification." Please note that kidney transplants are not subject to additional reimbursement for organ acquisition.
- The organ recipient must be Medicaid-eligible for acquisition costs to be reimbursed.
    - When both donor and recipient are Medicaid-eligible, the recipient Claim must be filed and paid first before submitting the donor Claim. The donor Claim must have the donor's Medicaid recipient name and ID number on the Claim.
    - When the donor is not Medicaid-eligible, the donor's Claim must have the Medicaid recipient's name and ID number on the Claim.

Unlisted Codes

Molina encourages Providers to bill with the most accurate and specific CPT or HCPCS code. If an unlisted code is used, documentation is required for all unlisted codes submitted for reimbursement. Documentation should include, but is not limited to:

- Complete description of the unlisted code
- Procedure/operative report for unlisted surgical/procedure code
- Invoice for unlisted DME/supply codes

- NDC number, dose and route of administration for the drug billed

Documentation will be reviewed for appropriate coding and existence of a more appropriate code. Claims submitted with unlisted codes that do not have documentation with them and no prior authorization on file will be denied.

Urgent Care Services

Molina requires all services rendered at an urgent care facility be billed with Place of Service 20. This is required for Claims to process accurately against urgent care benefits in the Molina Claims processing system.

F. MyCare Ohio Billing Guidelines

As stated in the three-way agreement between MCPs, ODM and CMS, Molina will offer at minimum all benefits included in Medicare Part A, Part B, and Part D as well as full state plan benefits. Providers should bill in accordance with CMS billing guidelines for all Medicare Covered Services. For non-Medicare Covered Services, Providers should bill with ODM billing guidelines.

Long-Term Care

Nursing Facilities (NF):

Molina follows CMS and ODM billing guidelines for skilled and custodial levels of care. For skilled Members, Molina reimburses based on current Resource Utilization Groups (RUG) rates. For custodial Members, Molina will reimburse Claims based on the current per diem rate of the facility set forth by ODM. The following services are included in the NF per diem rate and will not be separately reimbursed for custodial Members:

- Costs incurred for physical therapy, occupational therapy, speech therapy and audiology services provided by licensed therapists or therapy assistants are reimbursed through the nursing facility per diem.
- Costs incurred for the services of a licensed psychologist are reimbursable through the nursing facility per diem. No reimbursement for psychologist services shall be made to a Provider other than the nursing facility, or a community mental health center certified by the ODMHAS.
    - Services provided by an employee of the community mental health center must be billed directly to Molina by the community mental health center.
- Costs incurred for physician-ordered administration of aerosol therapy that is rendered by a licensed respiratory care professional are reimbursable through the nursing facility per diem. No reimbursement for respiratory therapy services shall be made to a Provider other than the nursing facility through their per diem rate.

Medicaid bill types:

- Medicaid inpatient Claim 213
- Medicaid corrected Claims 217
- Medicaid void Claims 218

Medicaid revenue (Rev) codes:

- Regular/full day covered/non-covered day 0101
- Full day: short-term NF stay for waiver consumer 0160
- Therapeutic leave day 0183
- Hospital leave day 0185
- PA1/PA2 flat fee full day 0220
- PA1/PA2 flat fee short-term stay for waiver consumer 0169
- PA1/PA2 flat fee leave day 0189

Other bill types as noted below under Medicare Part A can be used, but these are the most frequent. Religious Nonmedical Health Care Institutions should use bill type 041X.

SNF Part A bill types:

- Admit through discharge 211
- Interim, first Claim 212
- Interim, continuing Claim 213
- Final Claim 214
- Late charges only Claim 215
- Replacement prior Claim 217
- Void/cancel prior Claim 218

SNF Part B only bill types:

- Admit through discharge 221
- Interim, first Claim 222
- Interim, continuing Claim 223
- Final Claim 224
- Late charges only Claim 225
- Replacement prior Claim 227
- Void/cancel prior Claim 228

SNF outpatient:

- Admit through discharge 231
- Interim, first Claim 232
- Interim, continuing Claim 233
- Final Claim 234
- Late charges only Claim 235
- Replacement prior Claim 237

- Void/cancel prior Claim 238

Medicare Part A condition codes:

Field 18-28: Required when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. This list of codes including instructions can be found in NUBC UB04 Uniform Billing Manual.

Medicare Part A occurrence codes and occurrence span codes:

Field 35-36: Occurrence codes and occurrence span codes are typically used when there is a coordination of benefits. This list of codes and instructions can be found in NUBC UB04 Uniform Billing Manual.

Assisted living services:

- The service furnishes 24-hour on-site response capability, personal care, supportive services (homemaker and chore), and the coordination of the provision of three meals a day and snacks.

Nursing and skilled therapy services are incidental, rather than integral, to the provision of the assisted living service. Required nursing services include health assessment and monitoring, medication management including medication administration, and the delivery of part-time intermittent nursing and skilled nursing up to the maximum allowed in OAC 3701-16-09 Personal Care Services; Medication Administration; Resident Medications; Application of Dressings; Supervision of Therapeutic Diets when not available through a third party.

Skilled therapy (physical therapy, occupational therapy, speech-language pathology services and audiology services) are considered non-institutional professional services furnished by skilled therapists and skilled therapist assistants or aids based on OAC 5160-8-35 Skilled Therapy Services.

The scope of the service does not include 24-hour skilled care, one-on-one supervision, or the provision of items of comfort or convenience, disposable medical supplies, durable medical equipment, prescription medications or over-the-counter medications.

Limits: The service is limited to one unit per calendar day.

Molina requires the correct HCPCs and modifier combination billed on every Claim. For additional information see the LTSS Waiver Billing Guidelines on our Provider Website, under the “Manual” tab, on the “Quick Reference Guides & FAQs” page.

Hospice Services: OAC 5160-56-06 Hospice Services Reimbursement

Effective June 1, 2021, Providers are required to bill hospice services on a CMS-1500 form. Providers will need to follow all CMS-1500 rules, which include filling out Box 32 and 32a, as appropriate. As a reminder, Box 32 is used to indicate the service location name, address and NPI information for the location where the services were provided.

Providers **MUST** complete Boxes 32 and 32a as follows, when appropriate:

- Box 32: Must contain the Service Location information for a facility.
- Box 32a: Must contain the NPI of the Service Location. Note: There will be no service location information for services that are billed as home services; i.e., services performed in the member's home.

The Hospice HCPCS code set includes:

- G0155 Social Worker Visit, Service Intensity Add-on (SIA)
- G0299 Registered Nurse Visit, SIA
- T2042 Routine Hospice
- T2043 Continuous Home Care Hospice
- T2044 Inpatient Respite Care
- T2045 General Inpatient Care
- T2046 Hospice Room and Board: This requirement is for standard Hospice Room and Board billing. Note: The exception to this is Hospice Room and Board for Health Care Isolation Center (HCIC) and Vent/Vent Weaning. These are required to be billed on a UB-04 with the appropriate revenue code. (Refer to next page for more detail)

Molina updated these Claims guidelines to more closely align with other Managed Care Plans to help reduce administrative burden on our provider partners.

Routine Hospice Tiered Pricing

Effective Federal Fiscal Year (FFY) 2017, changes reflect a tiered payment methodology for Routine Home Care, code T2042 and the addition of SIA payment code G0155.

- Tiered payment methodology - Routine Home Care will be paid at a single per day rate for days 1-60 and at a different single per day rate for days 61+.
- SIA – This code (G0155) does require a prior authorization for payment.

Hospice Room and Board Services

When a Molina Member resides in a nursing facility (NF) and is receiving services from a hospice Provider, the hospice Provider must bill Medicaid MCPs and MyCare Ohio plans for room and board. The plans will be required to pay room and board payments directly to the hospice Provider for services rendered verses the nursing facility.

- Bill for days the Member is in the NF or Intermediate Care Facility for the Mentally Retarded (ICF/MR) overnight and only on days where the individual receives routine home care or continuous home care.

- Bill for patients who are Medicare and Medicaid eligible; Medicare for services provided under the Medicare hospice benefit and Medicaid for the individual's room and board.

Molina will reimburse 95% of the facility per diem rate in accordance with OAC 5160-56-06 Hospice Services Reimbursement

Managed Long-Term Services and Supports (MLTSS)

During the TOC period MLTSS/waiver services will need to be billed with the appropriate procedure codes and modifiers based on the legacy/waiver of origin as specified in the OAC. Once the TOC period is over, Provider will be required to bill with the appropriate procedure code and modifier combinations for Molina's combined waiver. For a complete list of codes and modifier combinations, please refer to the LTSS Waiver Services Billing Guide found in the Provider Training section of Molina's website at MolinaHealthcare.com/OhioProviders.

Custom Wheelchairs and Wheelchair Repairs

Billing Requirements for each line of business

Medicare and MMP Medicare:

- Code(s)/modifier(s): See applicable Medicare and/or Medicaid fee schedules and the Medicaid Supply List (See link in References below)
- Form Type: HCFA 1500
- Covered Service: Please refer to the applicable Medicare and/or Medicaid fee schedules (See References below)
- Primary Explanation of Benefit (EOB) is not required
- Prior Authorization (PA) Required: Refer to the applicable Prior Authorization Form and Instructions at MolinaHealthcare.com/OhioProviders.
- Medicare does apply a cost share

Medicaid and MMP Medicaid:

- Code(s)/modifier(s): See applicable Medicare and/or Medicaid fee schedules and the Medicaid Supply List (See link in References below)
- Form Type: HCFA 1500
- Covered Service: Please refer to the applicable Medicare and/or Medicaid fee schedules (See References below)
- Primary Explanation of Benefit (EOB) is required other than place of service (POS) 32, when Medicare is primary
- Prior Authorization (PA) Required: Refer to the applicable Prior Authorization Form and Instructions at MolinaHealthcare.com/OhioProviders.
- Coordination of Benefits (COB) method is lesser of Medicaid maximum or cost share

Marketplace:

- Code(s)/modifier(s): See applicable Medicare and/or Medicaid fee schedules and the Medicaid Supply List (See link in References below)
- Form Type: HCFA 1500
- Covered Service: Please refer to the applicable Medicare and/or Medicaid fee schedules (See References below)
- Primary Explanation of Benefit (EOB) is required other than POS 31, 32, 33 when Medicare is primary
- Prior Authorization (PA) Required: Refer to the applicable Prior Authorization Form and Instructions at MolinaHealthcare.com/OhioProviders.
- Coordination of Benefits (COB) method is lesser of Medicaid maximum or cost share

Custom Wheelchair Summary: DME Pricing/Invoice Pricing

In accordance with OAC 5160-10-01 Medical Supplies, Durable Medical Equipment, Orthoses, and Prosthesis Providers, payment for durable medical equipment (DME) – including custom wheelchairs, power wheelchairs and all wheelchair parts and accessories – as well as medical supplies, orthotics or prosthetics, is reimbursed using the following criteria:

(1) When the item or items appear in OAC 5160-1-60 Medicaid Payment – Appendix DD, the Provider shall bill the department the Provider's usual and customary charge and will receive the lesser of the usual and customary charge or the Medicaid maximum rate that appears in this appendix; or
(2) When the item or items do not appear in OAC 5160-1-60 Medicaid Payment – Appendix DD or appear but without a Medicaid maximum rate and the Provider has submitted a list price for payment, the Provider shall bill the usual and customary charge and will receive the lesser of the usual and customary charge or 72 percent of the list price; or
(3) When the item or items in question do not appear in OAC 5160-1-60 Medicaid Payment – Appendix DD or appear but without a Medicaid maximum rate and the Provider has submitted an invoice price for payment, the Provider shall bill the usual and customary charge and will receive the lesser of the usual and customary charge or 147 percent of the invoice price less any discounts or rebates applicable at the time of billing but exclusive of any discounts or rebates the Provider may receive subsequent to the time of billing; or
(4) In circumstances where paragraph (1), (2) and (3) listed above occur concurrently, the department will reimburse the amount determined to be the most cost effective.
(5) The "list price" is defined as the most current price recommended by the manufacturer for retail sale. This price cannot be established nor obscured or deleted by the Provider on any documentation supplied for consideration of reimbursement. A Provider may set the list price for custom products where the Provider is both the manufacturer and the Provider so long as the list price is equal to or less than comparable products. Documentation submitted to support this price is subject to approval by the department.

(6) The "invoice price" is defined as the price delivered to the consumer and reflects the Provider's net costs in accordance with OAC 5160-10-01 Durable medical equipment, prostheses, orthoses, and supplies (DMEPOS): general provisions . This information cannot be obscured or deleted on any documentation supplied for consideration of reimbursement. Documentation submitted to support this price is subject to approval by the department.
(7) Costs of delivery and service calls related to DME, medical supplies, orthotics or prosthetics are considered an integral part of the Provider's cost of doing business. A charge for these services will not be recognized when billed separately.
(8) The consumer must be supplied with the most cost effective DME, medical supply, orthotic or prosthetic that meets their clinical needs. Cost effective is defined to mean items which meet the consumer's clinical and lifestyle requirements at the lowest available cost.
(9) A supplier of custom items may be reimbursed when the consumer for whom they were intended expires prior to dispensing under the following conditions:
   a. The Healthcare Common Procedure Coding System (HCPCS) code used to describe the item indicates it is designed or intended for a specific individual; and
   b. The item cannot be modified for use by another individual; and
   c. The Provider can document measurements of the consumer were taken for fitting prior to the end of life; and
   d. The Provider can document the consumer's health status at the time the item was requested did not indicate the end of life was imminent; and
   e. The Provider uses the date the consumer's measurements were taken as the date of service for the item.

Wheelchair Repairs

Molina follows the DME guidelines as referenced in the Ohio Department of Medicaid Durable Medical Equipment, Prosthesis, Orthoses, and Supplies. It is imperative that appropriate billing be used to identify the services provided and process Claims accurately.

- OAC 5160-10-01 – Appendix, Medicaid Supply List
  - Follow Molina PA requirements
- OAC 5160-10-16 DMEPOS: Wheelchairs
  - This includes power operated vehicles (POVs). Paragraph (G) gives the coverage and limitations for eligibility of these items.
  - According to paragraph (J)(7), Repair and replacement:
    - A current prescription must be submitted with a request for authorization of a repair when the department did not authorize the purchase of the wheelchair. In this case, a current prescription and documentation of Medical Necessity must be submitted with the initial request for repair. If the wheelchair is determined to be Medically Necessary and the repair is authorized, subsequent repairs may be authorized

without the submission of a current prescription and documentation of Medical Necessity.

- According to paragraph (J) (8), for a consumer who resides in a personal residence, reimbursement may be authorized for the repair of a consumer-owned wheelchair that is not eligible for purchase in accordance with this rule, if it is determined that the wheelchair meets the seating/wheeled mobility needs of the consumer and it would be more cost effective for the department to authorize the repair rather than the replacement of the wheelchair. Authorization for the repair of a wheelchair does not necessarily indicate that the wheelchair would be authorized for purchase. Replacement of any consumer-owned wheelchair will be authorized in accordance with this rule.

- OAC 5160-10-02 Repair of Medical Equipment
  - According to paragraph (A)(1)(c), Providers must submit the appropriate procedure code(s) including modifiers as required for all equipment repair Claims submissions and PA requests. For the reimbursement of repairs requiring materials and labor, the appropriate procedure codes must be submitted together on the same Claim for the same date of service.
  - According to paragraph (A)(1)(d), all wheelchair and POV repairs must be billed in accordance with OAC 5160-10-16 Wheelchairs.
    - For the reimbursement of repairs or replacement of parts of wheelchairs without a specific procedure code, use code K0108 modified with the RB modifier in combination with labor code K0739 as appropriate.

References

- Medicare Claims Processing Manual
- Medicare DMEPOS Fee Schedule
- Medicaid Provider Manual – Please refer to the Claims and Encounter Data section for DME.
- OAC 5160-10-01 Durable Medical Equipment, Prosthesis, Orthoses, and Supplies (DMEPOS): General Provisions
- OAC 5160-1-60 Medicaid Payment – Appendix DD
- OAC 5160-10-02 Repair of Medical Equipment

G. Modifiers: HIPAA Compliant Modifiers That Impact Claims Payment

For a complete list of modifiers, please refer to the HCPCS/CPT books, or EncoderPro online.

Ambulance Modifiers signifying to or from a Nursing Facility (NF):

In accordance with OAC 5160-3-19 Nursing Facilities (NFs): Relationship of NF Services to Other Covered Medicaid Services, payment is made directly to the transportation supplier in accordance with Chapter 5160-15 of the Administrative Code. Transportation of residents to receive medical services when the resident does not require an ambulance or wheelchair van is paid through the NF per diem.

- Ohio Administrative Code (OAC) 5160-15 Medical Transportation Services
- OAC 5160-3-19 Nursing Facilities (NFs): Relationship of NF Services to Other Covered Medicaid Services
- DN, ND, EN, NE, GN, NG, HN, NH, IN, NI, JN, NJ, NN, PN, NP, RN, NR, SN, NS, NX, XN

Anesthesia Service Modifiers:

- Ohio Administrative Code (OAC) 5160-4-21 Physician Services: Anesthesia Services
- AA: Anesthesia services personally furnished by anesthesiologist
- AD: Medical supervision by a physician; more than four concurrent anesthesia procedures
- QK: Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
- QX: Certified Registered Nurse Anesthetist (CRNA) with medical direction by a physician or anesthesia assistant with medical direction by an anesthesiologist
- QY: Medical direction of one CRNA by an anesthesiologist
- QZ: CRNA without medical direction by a physician

Behavioral Health Service Modifiers:

- OAC 5160-8-05 Behavioral Health Services – Other Licensed Professionals
- AH: A clinical psychologist
- AJ: A clinical social worker
- HN: A bachelor's level clinical staff person
- HO: A master's degree level trained professional
- HP: A doctoral level trained professional
- XE: Service that is distinct because it occurred during a separate encounter
- XP: Service that is distinct because it was performed by a different practitioner
- XS: Service that is distinct because it was performed on a separate organ/structure
- XU: Service that is distinct because it does not overlap usual components of the main service

Durable Medical Equipment (DME) Modifiers:

- BO: Enteral nutrition that is given orally
- NU: New equipment is purchased
- QE: Prescribed amount of oxygen is one liter per minute or less

- QF: Prescribed amount of oxygen is greater than four liters per minute continuous and portable oxygen is also prescribed
- QG: Prescribed amount of oxygen is greater than four liters per minute continuous and portable oxygen is not prescribed
- RP: Repair/Replaced
- RR: Short term rental
- U1: Shall be used when oxygen services are provided via the use of a stationary oxygen concentrator to a consumer in a private residence
  - OAC 5160-10-13 DMEPOS Oxygen
- UE: Used equipment

Home Health Modifiers:

- OAC 5160-1-39 Verification of Home Care Service Provision to Home Care Dependent Adults
- OAC 5160-12-04 Home Health and Private Duty Nursing: Visit Policy
- OAC 5160-12-05 Reimbursement: Home Health Services
- OAC 5160-12-06 Reimbursement: Private Duty Nursing Services
- U1: Infusion therapy – Must be used when code T1000 is used for the purpose of home infusion therapy
- U2: Second visit – Must be used to identify the second visit for the same type of service made by a Provider on a date of service per consumer
- U3: Third visit or more – Must be used to identify the third or more visit for the same type of service made by a Provider on a date of service per consumer
- U4: 12 hours to 16 hours per visit – Must be used when a visit is more than 12 hours, but not does not exceed 16 hours
- HQ: Group visit – Indicates that a group visit was done

Additional Modifiers:

- 22: Increased procedural service requiring work substantially greater than typically required
- 24: Unrelated evaluation and management service by the same physician during the postoperative period
  - OAC 5160-4-06 Specific Provisions for Evaluation and Management (E&M) Services
- 26: Professional component of a procedure that has both a technical and professional component
  - OAC 5160-1-60 Medicaid Payment
  - OAC 5160-4-25 Laboratory and Radiology Services
- 50: Bilateral procedures performed; reference OAC 5160-4-22 Surgical Services for physician Claims. Modifier 50 should not be used to report:
  - Procedures that are bilateral by definition or their descriptions include the terminology as “bilateral” or “unilateral.”
  - Dates of service prior to Aug. 1, 2017

    - Modifier 50 should not be used to report diagnostic and radiology facility services. Institutional Claims received for an outpatient radiology service appended with modifier 50 will be denied.
  - Dates of service on or after Aug. 1, 2017
    - Modifier 50 is required for radiology unless the code is written as a bilateral procedure or service.
- 51: Multiple procedures performed; OAC 5160-4-22 Surgical Services
- 52: Reduced Services for Outpatient Hospital Services and Ambulatory Surgery Center Services
- 62: Co-Surgical Services
  - Multiple surgery pricing reduction applies to surgical services, even when performed as a co-surgery.
  - OAC 5160-4-22 Surgical Services
- 73: Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia
  - OAC 5160-2-75 Outpatient Hospital Reimbursement
- 74: Discontinued outpatient hospital/ASC procedure after administration of anesthesia; hospital billing only
  - OAC 5160-2-75 Outpatient Hospital Reimbursement
- 80: Assistant-at-surgery services; valid only for physicians
  - OAC 5160-4-22 Surgical Services
- AS: Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery (Jan. 1, 2017)
- EP: Services provided as part of Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Healthchek Program
  - OAC 5160-1-14 Healthchek: EPSDT Covered Services
- GC: GC services performed in part by a resident under the direction of a teaching physician
  - OAC 5160-4 Medical and Surgical Services
- QW: Waived laboratory procedure performed in accordance with CLIA guidelines
- GE : Services performed by a resident without the presence of a teaching physician under the primary care exception rule
  - OAC 5160-4 Medical and Surgical Services
- SA: Nurse practitioner rendering service in collaboration with physician
- SB: Nurse mid-wife
- SG: Facility charge for free-standing ASC
- TC: Technical component of procedure performed in a non-hospital setting
  - OAC 5160-1-60 Medicaid Payment
  - OAC 5160-4-25 Laboratory and Radiology Services
- TH: Obstetrical treatment/services, prenatal or post-partum
  - OAC 5160-21 Preconception Care Services
- UB: Transport of critically ill or injured patient more than 24 months of age

  - OAC 5160-4-06 Specific Provisions for Evaluation and Management (E&M) Services
- UC: Clinical nurse specialist
- UD: Physician assistant
  - OAC 5160-4-03 Physician Assistants
- GQ: Telemedicine originating service was also present during the visit
- GT: Telemedicine service rendered as a distant site

Type of Bill Codes: This is a three-digit code; each digit is defined below:

- First Digit – Type of Facility
  - Hospital: Code 1
  - Skilled Nursing Facility: Code 2
  - Home Health: Code 3
  - Christian Science (Hospital): Code 4
  - Christian Science (Extended Care): Code 5
  - Intermediate Care: Code 6
  - Clinic: Code 7
  - Special Facility or Hospice: Code 8
- Second Digit – Bill Classifications (Excluding Clinics & Special Facilities)
  - Inpatient (Part A): Code 1
  - Inpatient (Part B): Code 2
  - Outpatient: Code 3
  - Other (for Hospital Referenced Diagnostic Services, or Home Health Not Under a Plan of Treatment): Code 4
  - Intermediate Care, Level I: Code 5
  - Intermediate Care, Level II: Code 6
  - Intermediate Care, Level III: Code 7
  - Swing Beds: Code 8
- Second Digit: Bill Classifications (Clinics Only)
  - Rural Health: Code 1
  - Hospital Based or Independent Renal Dialysis Center: Code 2
  - Free Standing: Code 3
  - Other Rehabilitation Facility (ORF): Code 4
  - Other: Code 9

Type of Bill Codes: This is a three-digit code; each digit is defined below:

- First Digit
  - Rural Health: Code 1
  - Hospital Based or Independent Renal Dialysis Center: Code 2
  - Free Standing: Code 3
  - Other Rehabilitation Facility (ORF): Code 4
  - Other: Code 9

- Second Digit – Bill Classifications (Special Facility Only)
  - Hospice (Non-Hospital Based): Code 1
  - Hospice (Hospital Based): Code 2
  - Ambulatory Surgery Center (ASC): Code 3
  - Free-standing Birthing Center: Code 4
- Third Digit – Frequency
  - Admit through Discharge Claim: Code 1
  - Interim – First Claim: Code 2
  - Interim – Continuing Claims: Code 3
  - Interim – Last Claim: Code 4
  - Late Charge Only: Code 5
  - Replacement of Prior Claim: Code 7
  - Void/Cancel of Prior Claim: Code 8

Claim Form Requirements Guide: CMS HCFA 1500

Mandatory: Item is required for all Claims. If the item is left blank, the Claim cannot be processed. The following fields are mandatory:

- Field 1a – Medicaid ID number
- Field 2 – Patient's name
- Field 3 – Patient's birth date and sex
- Field 21 – Diagnosis or nature of illness or injury
- Field 25 – Federal tax ID number (check box/SSN or EIN)
- Field 28 – Total charge
- Field 30 – Balance due
- Field 31 – Signature of physician or supplier including degrees or credentials
- Field 33 – Company name (as listed on W-9), address, zip code, phone number
- Field 10a – Is patient's condition related to employment?
- Field 10b – Is patient's condition related to auto accident?
- Field 10c – Is patient's condition related to other accident?
- Field 24a – Date(s) of service
- Field 24b – Place of service
- Field 24d – Procedures, services or supplies CPT/HCPCS code(s)
- Field 24e – Diagnosis code (pointer)
- Field 24f – Charges
- Field 24g – Days or units
- Field 24I – Electromyography (EMG)-emergency - Y or N
- Field 24j – Rendering Provider ID number, Medicaid ID number and NPI number
- Field 33a – 10-digit NPI number of billing Provider
- Field 33b – Billing Provider Medicaid ID number

Conditional: Item is required if applicable. Your Claim may not be processed if left blank. The following fields are conditional:

- Field 1 – Insurance
- Field 4 – Insured's name
- Field 5 – Patient's address
- Field 6 – Patient relationship to insured
- Field 7 – Insured's address
- Field 8 – Patient status
- Field 9 – Other insured's name
- Field 9a – Other insured's policy or group number
- Field 9b – Other insured's date of birth and sex
- Field 9c – Employer's name or school name
- Field 9d – Insurance plan name or program name
- Field 10d – Reserved for location use
- Field 11 – Insured's policy group or Federal Employee Compensation Act (FECA) number
- Field 11a – Insured's date of birth
- Field 11b – Employer's name or school name
- Field 11c – Insurance plan name or program name
- Field 11d – Is there another health benefit plan?
- Field 12 – Patient's or authorized person's signature
- Field 13 – Insured's or authorized person's signature
- Field 14 – Date of current illness, injury or last menstrual period (LMP) for pregnancy related
- Field 15 – If patient has had a same or similar illness, give first date
- Field 16 – Dates patient unable to work in current occupation
- Field 17 – Name of referring physician or other source
- Field 17a – ID number of referring physician
- Field 17b – 10-digit National Provider Identifier (NPI) of referring physician or other source
- Field 18 – Hospitalization dates related to current services
- Field 19 – Reserved for local use
- Field 20 – Outside lab/charges
- Field 22 – Medicaid resubmission code and original reference number
- Field 23 – Prior authorization number
- Field Shaded area of 24a – 11-digit National Drug Code (NDC) number and its supplemental information
- Field 24c – Type of service
- Field 24h – EPSDT/family plan
- Field 24k – Reserved for local use
- Field 26 – Patient's account number
- Field 27 – Accept assignment
- Field 29 – Amount paid

- Field 32 – Name and address of facility where services were rendered
- Field 32a – 10-digit NPI number of service facility location

Claim Form Requirements Guide: UB-04

Mandatory: Item is required for all Claims. If the item is left blank, the Claim cannot be processed. The following fields are mandatory:

- Field 1 – Company name as listed on W-9, address and phone number
- Field 4 – Type of bill
- Field 5 – Federal tax ID number
- Field 6 – Statement covers period
- Fields 8a-b – Patient identifier and name
- Fields 9a-d – Patient address
- Field 10 – Patient date of birth
- Field 11 – Patient sex
- Field 12 – Admission/start of care date
- Field 13 – Admission hour (for inpatient only)
- Field 14 – Type of admission
- Field 15 – Source of admission
- Field 17 – Patient discharge status*
- Field 42 – Revenue codes*
- Field 43 – Revenue description
- Field 44 – HCPCS code/rates (if applicable)
- Field 45 – Service date
- Field 47 – Total charges (by revenue code/HCPCS)
- Field 50 – Payer name
- Field 51 – Health plan identification number
- Field 55 – Estimated amount due from payer
- Field 56 – Billing Provider NPI number
- Field 57 – Billing Provider Medicaid number
- Field 60 – Member Medicaid recipient ID number
- Field 66 – Diagnosis and procedure code qualifier
- Field 67 – Principal diagnosis code and present on admission indicator
- Fields 67a-q – Other diagnosis codes
- Field 69 – Admitting diagnosis code

Conditional: Item is required if applicable. Your Claim may not be processed if left blank. The following fields are conditional:

- Field 2 – Pay-to name and address
- Field 3a – Patient control number
- Field 3b – Medical record number

- Field 16 – Discharge hour
- Fields 18-28 – Condition codes (if applicable)
- Field 29 – Accident state
- Fields 31-34 – Occurrence codes and dates (if applicable) *
- Fields 35-36 – Occurrence span codes and dates
- Fields 38a-d – Name and address of the party responsible for the bill
- Fields 39-41 a-d – Value codes and amounts (if applicable) *
- Field 43 – 11-digit NDC number and its supplemental information
- Field 46 – Service units
- Field 48 – Non-covered charges
- Field 52 – Release of information certification indicator
- Field 53 – Assignment of benefits certification indicator
- Field 54 – Prior payments (if applicable)
- Field 58 – Name of insured
- Field 59 – Patient's relationship to insured
- Field 61 – Insured's group name
- Field 62 – Insured's group number
- Field 63 – Treatment authorization code
- Field 64 – Document control number
- Field 65 – Employer name (of the insured)
- Fields 70a-c – Patient's reason for visit
- Field 71 – Prospective payment system (PPS) code
- Fields 72a-c – External cause of injury code
- Field 74 – Principle procedure code and date
- Fields 74a-e – Other procedure codes and dates
- Field 76 – Attending Provider name and identifiers
- Field 77 – Operating physician name and identifiers
- Fields 78-79 – Other Provider name and identifiers
- Field 80 – Remarks field

Not Used:

- Field 7 – Reserved for assignment by National Uniform Billing Committee (NUBC)
- Field 30 – Reserved for assignment by NUBC
- Field 37 – Reserved for assignment by NUBC
- Field 49 – Reserved for assignment by the NUBC
- Field 68 – Reserved for assignment for the NUBC
- Field 73 – Reserved for assignment of the NUBC
- Field 75 – Reserved for assignment of the NUBC
- Field 81 – Code – code field

*Refer to Uniform Billing Manual for List of Codes

XXI. Appendix B

Transition of Care - Molina Dual Options, MyCare Ohio Medicare-Medicaid Plan (MMP)

Transition Requirements:

- Assisted Living Waiver Service
  - **NF Beneficiaries/AL Beneficiaries**: Provider maintained at current rate for the life of Demonstration.
- Chemotherapy/ Radiation
  - **HCBS Waiver Beneficiaries**: Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified Provider
  - **Non-Waiver Beneficiaries with LTC Needs (HH and PDN Use)**: Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified Provider
  - **NF Beneficiaries/AL Beneficiaries**: Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified Provider
  - **Beneficiaries not Identified for LTC Services**: Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified Provider
- Dialysis Treatment:
  - **HCBS Waiver Beneficiaries**: 90 days with same Provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new Provider.
  - **Non-Waiver Beneficiaries with LTC Needs (HH and PDN Use)**: 90 days with same Provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new Provider.
  - **NF Beneficiaries/AL Beneficiaries**: 90 days with same Provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new Provider.
  - **Beneficiaries not Identified for LTC Services**: 90 days with same Provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new Provider.
- DME
  - **HCBS Waiver Beneficiaries**: Must honor PA's when item has not been delivered and must review ongoing PA's for Medical Necessity
  - **Non-Waiver Beneficiaries with LTC Needs (HH and PDN Use)**: Must honor PA's when item has not been delivered and must review ongoing PA's for Medical Necessity
  - **NF Beneficiaries/AL Beneficiaries**: Must honor PA's when item has not been delivered and must review ongoing PA's for Medical Necessity
  - **Beneficiaries not Identified for LTC Services**: Must honor PA's when item has not been delivered and must review ongoing PA's for Medical Necessity
- Medicaid Community Behavioral Health Organizations (Provider types 84 & 95)
  - **HCBS Waiver Beneficiaries**: Maintain current Provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.

  - **Non-Waiver Beneficiaries with LTC Needs (HH and PDN Use)**: Maintain current Provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.
  - **NF Beneficiaries/AL Beneficiaries**: Maintain current Provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.
  - **Beneficiaries not Identified for LTC Services**: Maintain current Provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.
- Medicaid Home Health and PDN
  - **HCBS Waiver Beneficiaries**: Maintain service at current level and with current Providers at current Medicaid reimbursement rates. Changes may not occur unless: A significant change occurs as defined in OAC 5160-45-01; or individuals expresses a desire to self-direct services; or after 365 days.
  - **Non-Waiver Beneficiaries with LTC Needs (HH and PDN Use)**: Sustain existing service for 90 days and then review for Medical Necessity after an in-person assessment that includes Provider observation
  - **NF Beneficiaries/AL Beneficiaries**: For AL: Sustain existing service for 90 days and then review for Medical Necessity after an in-person assessment that includes Provider observation
- Medicaid Nursing Facility Services
  - **NF Beneficiaries/AL Beneficiaries**: Provider maintained at current Medicaid rate for the life of Demonstration.
- Organ, Bone Marrow, Hematopoietic Stem Cell Transplant
  - **HCBS Waiver Beneficiaries**: Must honor specified Provider
  - **Non-Waiver Beneficiaries with LTC Needs (HH and PDN Use)**: Must honor specified Provider
  - **NF Beneficiaries/AL Beneficiaries**: Must honor specified Provider
  - **Beneficiaries not Identified for LTC Services**: Must honor specified Provider
- Physician
  - **HCBS Waiver Beneficiaries**: 90-day transition for individuals identified for high risk care management; 365 days for all others
  - **Non-Waiver Beneficiaries with LTC Needs (HH and PDN Use)**: 90-day transition for individuals identified for high risk care management; 365 days for all others
  - **NF Beneficiaries/AL Beneficiaries**: 90-day transition for individuals identified for high risk care management; 365 days for all others
  - **Beneficiaries not Identified for LTC Services**: 90-day transition for individuals identified for high risk care management; 365 days for all others
- Scheduled Surgeries
  - **HCBS Waiver Beneficiaries**: Must honor specified Provider
  - **Non-Waiver Beneficiaries with LTC Needs (HH and PDN Use)**: Must honor specified Provider

  - **NF Beneficiaries/AL Beneficiaries**: Must honor specified Provider
  - **Beneficiaries not Identified for LTC Services**: Must honor specified Provider
- Vision and Dental
  - **HCBS Waiver Beneficiaries**: Must honor PA's when item has not been delivered
  - **Non-Waiver Beneficiaries with LTC Needs (HH and PDN Use)**: Must honor PA's when item has not been delivered
  - **NF Beneficiaries/AL Beneficiaries**: Must honor PA's when item has not been delivered
  - **Beneficiaries not Identified for LTC Services**: Must honor PA's when item has not been delivered
- Waiver Services-Direct Care, Personal Care, Waiver Nursing, Home Care Attendant, Choice Home Care Attendant, Out of Home Respite, Enhanced Community Living, Adult Day Health Services, Social Work Counseling, Independent Living Assistance
  - **HCBS Waiver Beneficiaries**: Maintain service at current level and with current Providers at current Medicaid reimbursement rates. Plan initiated changes may not occur unless: A significant change occurs as defined in OAC 5160-45-01; or individual expresses a desire to self-direct services; or after 365 days.
- Waiver Services-All other
  - **HCBS Waiver Beneficiaries**: Maintain service at current level for 365 days and existing service Provider at existing rate for 90 days. Plan initiated change in service Provider can only occur after an in-home assessment and plan for the transition to a new Provider.

Transition of Care – Medicaid – For Members transitioning from the below programs to Molina:

- Ohio Medicaid Fee-For-Service (FFS)
- Other Ohio Managed Care Plans (MCPs)
- Newly Enrolled in the Ohio Medicaid Program

Molina will allow a new Member to receive services from network and out-of-network Providers, as indicated, if any of the following apply:

- If Molina confirms that the Adult Extension Member is currently receiving care in a nursing facility on the effective date of enrollment with Molina, Molina will cover the nursing facility care at the same facility until a Medical Necessity review is completed and, if applicable, a transition to an alternative location has been documented in the Member's care plan.
- Upon becoming aware of a pregnant Member's enrollment, Molina will identify the Member's maternal risk and facilitate connection to services and supports in accordance with ODM's *Guidance for Managed Care Plans for the Provision of Enhanced Maternal Care Services.* These services and supports include delivery at an appropriate facility and continuation of progesterone therapy covered by Medicaid FFS or another MCP for the duration of the pregnancy. In addition, Molina will allow the pregnant Member to continue with an out-of-network Provider if they are in their third trimester of pregnancy and/or has an established relationship with an obstetrician and/or delivery hospital.

- **If a PA is on file:** Molina will honor any PAs approved prior to the Member's transition to Molina through the expiration of the authorization period, based on the Member's effective date with Molina; regardless of whether the authorized or treating Provider is in or out-of-network with Molina.
  - Molina may conduct a Medical Necessity review for previously authorized services if the Member's needs change to warrant a change in service. Molina will render an authorization decision pursuant to OAC rule 5160-26-03.1.
  - Molina may assist the Member to access services through a network Provider when any of the following occur
    - The Member's condition stabilizes, and Molina can ensure no interruption to services;
    - The Member chooses to change to a network Provider; or
    - If there are quality concerns identified with the previously authorized Provider.
  - Scheduled inpatient or outpatient surgeries approved and/or pre-certified shall be covered pursuant to OAC rule 5160-2-40 (surgical procedures would also include follow-up care as appropriate);
  - Organ, bone marrow, or hematopoietic stem cell transplant shall be covered pursuant to OAC rule 5160-2-65 and Appendix G of the Agreement between Molina and ODM;
- **If no PA is on file:** Molina will provide the following services to the Member regardless of whether services were prior authorized/pre-certified, or the treating Provider is in or out-of-network with the MCP. Timeframes for the services are below:
  - Chemotherapy or Radiation - within 30 days of the Member's effective date with Molina.
  - Durable Medical Equipment (DME) – within 30 days of the Member's effective date with Molina. DME shall be covered at the same level with the same Provider as previously covered until Molina conducts a Medical Necessity review and renders an authorization decision pursuant to OAC rule 5160-26-03.1.
  - Home Care and Private Duty Nursing (PDN) Services – within 30 days of the Member's effective date with Molina. Private Duty Nursing and home care services shall be covered at the same level with the same Provider as previously covered until Molina conducts a Medical Necessity review and renders an authorization decision pursuant to OAC rule 5160-26-03.1.
  - Hospital Discharge – Molina will continue with treatment if the Member was discharged 30 days prior to Molina's enrollment effective date within 30 days of the Member's effective date with Molina.
  - Medicaid Community Behavioral Health Services – Members can see out-of-network Providers within 30 days of the Member's effective date with Molina. If a Member is unable to obtain Medically Necessary services from a Molina network Provider, Molina will adequately and timely cover the services out-of-network until Molina is able to provide the services from a network Provider. For continuity of care purposes, Molina will:
    - Work with the service Provider to add the Provider to their network;

    - Implement a single case agreement with the Provider; or
    - Assist the Member in finding a Provider currently in Molina's network
  - Physician Services - within 30 days of the Member's effective date with Molina, then must be transitioned to a network Provider or Medical Necessity for seeing an out-of-network Provider must be established
  - Prescribed drugs shall be covered without PA for at least the first 90 days of membership, or until a Provider submits a PA and the MCP completes a Medical Necessity review, whichever date is sooner. The MCP shall educate the Member that further dispensation after the first 90 days will require the prescribing Provider to request a PA. If applicable, the MCP shall offer the Member the option of using an alternative medication that may be available without PA. Written Member education notices shall use ODM-specified model language. Verbal Member education may be substituted for written education but shall contain the same information as a written notice. Written notices or verbal Member education shall be prior approved by ODM.
  - Upon notification from a Member and/or Provider of a need to continue services, the MCP shall allow a new Member to continue to receive services from network and out-of-network Providers when the Member could suffer detriment to their health or be at risk for hospitalization or institutionalization in the absence of continued services.

Hospital: Change in Enrollment During Hospital/Inpatient Facility Stay: Process between Managed Care Plans

- When the MCP learns of a currently hospitalized Member's intent to disenroll through the Consumer Contact Record (CCR) or the HIPAA 834:
  - The disenrolling MCP shall notify the hospital/inpatient facility and treating Providers as well as the enrolling MCP, if applicable, of the change in enrollment.
  - The disenrolling MCP shall notify the inpatient facility that it will remain responsible for the inpatient facility charges through the date of discharge; and shall notify the treating Providers that it will remain responsible for Provider charges through the date of disenrollment.
  - The disenrolling MCP shall not request and/or require that a disenrolled Member be discharged from the inpatient facility for transfer to another inpatient facility.
  - Should a discharge and transfer to another inpatient facility be Medically Necessary, the disenrolling MCP shall notify the treating Providers to work with the enrolling MCP or ODM as applicable to facilitate the discharge, transfer, and authorization of services as needed.
- When the enrolling MCP learns through the disenrolling MCP, through ODM or other means, that a new Member who was previously enrolled with another MCP was admitted prior to the effective date of enrollment and remains an inpatient on the effective date of enrollment, the enrolling MCP shall:
  - Contact the hospital/ inpatient facility

  - Verify that it is responsible for all Medically Necessary Medicaid Covered Services from the effective date of MCP membership, including professional charges related to the inpatient stay
  - Inform the hospital/inpatient facility that the admitting/disenrolling MCP remains responsible for the hospital/inpatient facility charges through the date of discharge.
  - Work with the hospital/inpatient facility to facilitate discharge planning and authorize services as needed.
- When the MCP learns that a new Member who was previously on Medicaid FFS was admitted prior to the effective date of enrollment and remains an inpatient on the effective date of enrollment, the MCP shall notify the hospital/inpatient facility and treating Providers that the MCP is responsible for the professional charges effective on the date of enrollment, and shall work to ensure discharge planning provides continuity using MCP-contracted or authorized Providers.

If a Member has been admitted to a hospital prior to the first day of Medicaid eligibility and no retroactivity occurs, the MCP is responsible for reimbursement of the inpatient Claim for the days the Member is enrolled in the MCP only. The days prior to eligibility would be considered non-covered days, and the Claim will be processed on a per diem payment basis as partial eligibility. In addition, if a Member loses Medicaid coverage during and inpatient stay prior to discharge, payment will be made on a per diem basis up to and including the termination date with Molina. The days after termination of coverage with Molina would be considered non-covered days and the claim will be processed on a per diem basis as partial eligibility. Therefore, in both scenarios, the claim should be billed with all days included, with the days outside of Molina eligibility billed as non-covered days.