

Provider Manual

Molina Healthcare of South Carolina

Medicaid 2022



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.

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Section 1. Contact Information

Molina Healthcare of South Carolina

Molina Healthcare of South Carolina
PO Box 40309
North Charleston, SC 29423-0309

Provider Services Department

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

Phone: (855) 237-6178

Hours of Operation: Monday-Friday, 8 a.m. to 5 p.m., local time

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 from 8 a.m. to 6 p.m. Monday through Friday, excluding State holidays. Eligibility verifications can be conducted at your convenience via the Provider Portal.

Phone: (855) 882-3901

TTY/TDD: 711

Fax: (844) 834-2155

Email: MHSCMemberServices@MolinaHealthcare.com

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 (<https://Provider.MolinaHealthcare.com>)
- EDI Payer ID 46299

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.

Molina Healthcare of South Carolina
PO Box 602960
Charlotte, NC 28260-2960

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.

Confidential
Compliance Official
Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802
Phone: (866) 606-3889
Online: [https://MolinaHealth Care.alertline.com](https://MolinaHealthCare.alertline.com)

Credentialing Department

The Credentialing department verifies all information on the Provider Application prior to contracting and re-verifies 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.

Email: MSC-CREDENTIALING@MolinaHealthcare.com

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 to assess symptoms and help make good health care decisions.

- English Phone : (844) 800-5155
- Spanish Phone : (866) 648-3537
- TTY English : (866) 735-2929
- TTY Spanish : (866) 833-4703

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 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 representative for registration and submission guidance
- Submit requests via 278 transactions. See the EDI transaction section of Molina's website for guidance.

Provider Portal : Provider.MolinaHealthcare.com

Phone : (855) 237-6178

Prior Authorization Fax : (866) 423-3889

Health Management

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

Weight Management and Smoking Cessations 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 Member behavioral health needs, please contact us directly at (855) 882-3901. Molina has a Behavioral Health Crisis Line that Members may access 24 hours per day, 365 days per year by calling the Member Services telephone number on the back of their Molina ID card.

Pharmacy Department

A list of in-network pharmacies is available on the MolinaHealthcare.com website or by contacting Molina.

Phone : (855) 237-6178

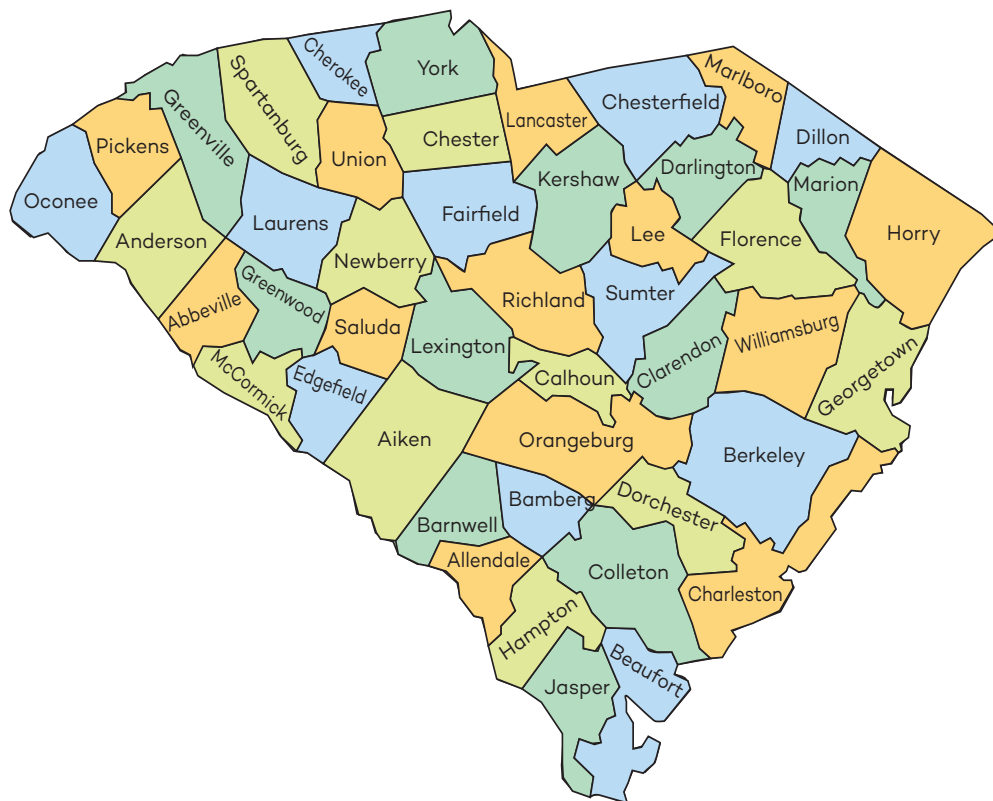
Quality

Molina maintains a Quality department to work with Members and Providers in administering the Molina Quality program.

Phone : (855) 237-6178

Molina Health Care of South Carolina Service Area

Includes all 46 counties



Section 2. Enrollment, Eligibility and Disenrollment

Enrollment in Medicaid Programs

The Medicaid Program is the program which implements Title XIX of the Social Security Act. It is administered by the South Carolina Department of Health and Human Services (SCDHHS) with a brand name of South Carolina Healthy Connections (SCHC). SCDHHS takes applications and determines eligibility of individuals and families for Medicaid coverage in the state. Further, for the majority of individuals and families who are eligible for Medicaid coverage and are eligible to participate in managed care, SCDHHS contracts with an enrollment brokerage service called South Carolina Healthy Connections Choices (SCHCC) to assist Medicaid-eligible Members with enrollment into a South Carolina-based managed care plan.

Only Medicaid recipients who are included in the eligible populations and living in counties with authorized Health Plans are eligible to enroll and receive services from Molina. Molina participates in the SCHC Medicaid program.

To enroll with Molina, the Member, his/her representative, or his/her responsible parent or guardian must complete and submit an application to SCHCC. More information about SCHCC and the application/enrollment process can be found at schchoices.com.

SCHCC will enroll all eligible Members with the health plan of their choice. If the Member does not choose a plan, SCHCC will assign the Member and his/her family to a plan that services the area where the Member resides.

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

Effective Date of Enrollment

Coverage shall begin as designated by SCDHHS on the first day of a calendar month. Before being assigned to a plan by SCDHHS, beneficiaries who are eligible for MCO plan assignment are given at least 30 days to choose a plan. Some beneficiaries not eligible for plan assignment may pro-actively enroll in a Managed Care Plan. Provided continued eligibility is maintained, all Members will be enrolled in a Managed Care Organization (MCO) for a period of 12 months. SCDHHS or its Agent will automatically enroll a Member into the MCO plan in which he/she was most recently enrolled if the Member had a temporary loss of eligibility of less than 60 days. In this circumstance, the consecutive enrollment period will continue as though there has been no break in eligibility, keeping the original 12 month period.

Newborn Enrollment

All newborns of Molina Members, where the newborn resided in the same household as the mother, are the responsibility of Molina. To assure continuity of care in the first months of the newborn's life, every effort will be made by SCDHHS to expedite the enrollment of the newborn into Molina. In cases where the newborn is not living with the mother, the newborn will be covered through fee-for-service Medicaid or be enrolled into a health plan by the person legally responsible for the newborn.

In cases where the mother was enrolled in Molina in the month of the birth, the newborn will be retroactively assigned to Molina, and will remain a Molina Member for the remainder of the year unless the mother changes plans during the second or third months of the newborn's life.

All Providers are required to notify Molina via the Pregnancy Notification Report (included in the Appendix of this manual) immediately after a positive pregnancy test and/or at the first prenatal visit of any Member presenting themselves for health care services.

Inpatient at time of Enrollment

Molina will cover facility charges for enrolled members from day of admission through discharge. If a member is enrolled or assigned to Molina while already being in an inpatient status, the payment for inpatient services will be provided by South Carolina Department of Health & Human Services (SC Medicaid Fee for Service) or another Medicaid Managed Care plan until time of discharge from the facility.

If a member switches to a new Medicaid Managed Care plan while admitted, the new plan will be responsible for payment of all professional services beginning with the effective date of enrollment.

Eligibility Verification

Medicaid Programs

The state of South Carolina, through SCDHHS determines eligibility for Medicaid coverage. A person must meet income and resource levels as well as non-income levels, including having U.S citizenship and being a South Carolina resident to be eligible for Medicaid coverage.

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.

The program is limited to certain Medicaid eligibles who:

- Do not also have Medicare
- Are under 65 years of age
- Are not in a nursing home at the time of enrollment
- Do not have limited benefits such as Healthy Connections Check Up, Specified Low Income Beneficiaries, Emergency Services only, etc.
- Are not participating in a Home or Community-Based Waiver program
- Are not participating in Hospice
- Are not participating in the PACE program
- Are not enrolled in a commercial MCO through third party coverage
- Are not enrolled in another Medicaid MCO

Eligibility Listing for Medicaid Programs



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

- Molina Provider Services at (855) 237-6178
- Eligibility can also be verified through the State by visiting <https://portal.scmecicaid.com/>
- Molina Provider Portal: <https://Provider.MolinaHealthcare.com>

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

Identification Cards

Molina Health Care of South Carolina Sample Member ID card

 Healthy Connections 	
Member: <Mem_Name_1> ID #: <Member_ID_1> DOB #: <Date_of_Birth_1>	Program: SC Medicaid
PCP Name: <PCP_name_1> PCP Phone: <PCP_Phone_Number_1> PCP Location: <PCP_Address_1> PCP Practice Name: <PCP_Group_Name_1>	RxBIN: 004336 RxPCN: ADV RxGRP: Rx0860
24 Hour Nurse Advice Line English: (844) 800-5155 Spanish: (866) 648-3537 TTY: 711	
MyMolina.com	

MEMBERS: If you have any questions, please visit our website at MolinaHealthcare.com or call Member Services at (855) 882-3901.

24 HOUR NURSE ADVICE LINE: If you have questions about your health, call our 24 hour Nurse Advice Line at (844) 800-5155 or (866) 648-3537 (Espanol). For hearing impaired, call TTY 711 or (866) 735-2929.

EMERGENCY SERVICES: Call 911 (if available) or go to the nearest emergency room or other appropriate setting. If you are not sure whether you need to go the emergency room, call your Primary Care Physician (PCP) at the number on the front of this card for instructions. Follow up with your PCP after all emergency room visits.

PRACTITIONERS/PROVIDERS/HOSPITALS: For prior authorizations, eligibility, claims or benefits visit the Molina Web Portal at MolinaHealthcare.com or call (855) 237-6178.

PHARMACISTS: For pharmacy authorization questions, please call (855) 237-6178.

Claims Submission: **PO BOX 22664, Long Beach, CA 90801**
EDI Claims: **Emdeon Payer ID: 46299**

Molina Healthcare
4105 Faber Place Drive, STE 120,
Charleston, SC 29405

MolinaHealthcare.com

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

Disenrollment

Voluntary Disenrollment

Members have the right to request to change plans once within the first 90 days of enrollment with a MCO and at the end of each 12 month enrollment period thereafter. Members may request to change plans for cause at any time. Circumstances that constitute cause for disenrollment include: the Member moving out of the service area, Molina does not provide covered services, Member seeks or refuses services based on moral or religious objections, Member needs services that are not available within the Molina network, Member's eligibility changes, or other reasons per 42 CFR 438.56(d)(2). Requests for disenrollment must be made to SCHCC. SCDHHS has final determination in all disenrollment requests.

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

Involuntary Disenrollment

Under very limited conditions and in accordance with SCDHHS guidelines, Members may be involuntarily disenrolled from a managed care program. With proper written documentation and approval by SCDHHS or its Agent, the following are acceptable reasons for which Molina may submit Involuntary Disenrollment requests to SCHCC:

- Molina ceases participation in the Medicaid Program in the Member's service area
- Member has moved out of the service area
- Member death
- Member becomes an inmate of a public institution
- Member elects Hospice

- Member's behavior is disruptive, abusive, or uncooperative and continued enrollment impairs the ability to furnish services to this Member or other Members
- Member's utilization of services is fraudulent or abusive
- Member is placed in a long-term care nursing facility/nursing home for more than 90 continuous days
- Member elects home-and community-based Waiver programs
- Member's Medicaid eligibility category changes, or Member otherwise becomes ineligible to participate in Medicaid
- Member becomes age 65 or older
- Member becomes Medicare eligible
- Member enrolls in a commercial MCO
- Member is placed out of home into an Intermediate Care Facility for the Intellectually Disabled

PCP Initiated Member Dismissal

A PCP may request the dismissal of a Member from his/her practice based on Member behavior. Reasons for dismissal must be documented by the PCP and may include:

- A Member who continues not to comply with a recommended plan of Health Care. Such requests must be submitted at least 45 calendar days prior to the requested effective date.
- A Member whose behavior is disruptive, unruly, abusive or uncooperative to the extent that his or her assignment to the Provider seriously impairs the Provider's ability to furnish services to either the Member or other patients/Members within their practice.

This section does not apply if the Member's behavior is attributable to a physical or behavioral condition.

Missed Appointments

The Provider will document and follow up on appointments missed and/or canceled by the Member. Providers should notify Molina's Health Education and Health Management department at (866) 891-2320 when a Member misses two consecutive appointments. This will enable Molina's Care managers a chance to outreach to Members to determine what barriers are preventing them from keeping scheduled appointments. Members who miss three consecutive appointments within a six-month period may be considered for disenrollment from a Provider's panel. Such a request must be submitted at least 45 calendar days prior to the requested effective date. The Provider agrees not to charge a Member for missed appointments.

A Member may only be considered for an involuntary disenrollment from a Provider's panel after the Member has had at least one verbal warning and at least one written warning of the full implications of his or her failure of actions. The Member must receive written notification in sixth grade reading level from the PCP explaining in detail the reasons for dismissal from the practice. Action related to request for involuntary disenrollment conditions must be clearly documented by Providers in the Member's records and submitted to Molina. The documentation must include attempts to bring the Member into compliance. A Member's failure to comply with a written

corrective action plan must be documented. For any action to be taken, it is mandatory that copies of all supporting documentation from the Member's file are submitted with the request. Molina will contact the Member to educate the Member in the consequences of behavior that is disruptive, unruly, abusive or uncooperative and/or assist the Member in selecting a new PCP. The current PCP must provide emergency care to the Member until the Member is transitioned to a new PCP.

PCP Assignment

Molina will assign a PCP to each Member at the time of enrollment. Molina will take into consideration the Member's last PCP (if the PCP is known and available in Molina's contracted network), closest PCP to the Member's home address by ZIP code location, family linkages, age (adults versus children/adolescents) and gender. Members may request a change of PCP's at any time. Molina will assign all Members that are reinstated after a temporary loss of eligibility of 180 days or less to the PCP who was treating them prior to loss of eligibility unless the Member specifically requests another PCP, the PCP no longer participates in Molina or is at capacity, or the Member has changed geographic areas.

Molina will allow pregnant Members to choose the Health Plan's obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP. Molina shall make available a pediatrician or other appropriate PCP to all pregnant Members for the immediate care of their newborn babies prior to delivery. Once the newborn's enrollment is received by Molina, if a PCP was not selected by the mother, an appropriate pediatrician will be assigned using the same logic as mentioned above.

PCP Changes

A Member may change their PCP at any time. The change will be effective on the date of initial enrollment, if the change is made prior to their effective date. Otherwise, the selected PCP will be effective the first date of the following month of eligibility.

Section 3. Member Rights and Responsibilities (Member Bill of Rights)

Molina members have rights and responsibilities that have been provided by SCHC. South Carolina law requires that health care Providers or health care facilities recognize Member rights while they 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 patients. In South Carolina, these rights are known as the Member Bill of Rights.

For a complete list of member rights, and responsibilities, please refer to the Molina Member Handbook. It can be found on the Molina website at MolinaHandbook.com/sc

Second Opinions

If a Member or Member's authorized representative does not agree with their Provider's plan of care, they have the right to request a second opinion from another Provider. Members should call Member Services to find out how to get a second opinion, and under what circumstances a second option can be obtained/approved.

Providers may also request a second opinion for a Member if certain clinical requirements are met. Providers should call Provider Services for additional information regarding Molina's Second Opinion Policy.

Section 4. Benefits and Covered Services

Molina benefits are comprehensive in nature and include all medically necessary services as included in the general fee-for-service SCHC Medical program as well as some expanded benefits.

There are no co-pays for Molina Members under the age of 19. Additionally, Molina has eliminated the co-pays for physician visits for Members over the age of 19. To find out additional information on which Members are exempt from co-pays, see the "Copay Exclusions" section of this Provider Manual.

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) 237-6178, Monday - Friday, 8 a.m. to 5 p.m., local time.

For a complete list of member benefits and covered services, please refer to the Molina Member Handbook. It can be found on the Molina website at MolinaHandbook.com/sc

Member Co-Pays for Services Covered by Molina Health Care of South Carolina

Member Cost Sharing

Cost Sharing is the copay 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 copay and other Member Cost Share from the Member to receive full reimbursement for a service. The amount of the copay and other Cost Sharing will be deducted from the Molina payment for all Claims involving Cost Sharing.

Copay Exclusions

Pursuant to Federal regulations, the following Members are excluded from copay requirements: children under the age of 19, pregnant women, institutionalized individuals (such as persons in a nursing facility or ICF-MR), Members of a Federally Recognized Indian Tribe (for services rendered by the Catawbas Service Unit in Rock Hill, SC and when referred to a specialist or other medical Provider by the Catawbas Service Unit) and Members of the Health Opportunity Account (HOA) program. Additionally, the following services are not subject to a copay: Medical equipment and supplies provided by DHEC, Orthodontic services provided by DHEC, Family Planning services, End Stage Renal Disease (ESRD) services, Infusion Center services, emergency services in the hospital emergency room, Hospice benefits and Waiver services.

Services Covered by SCDHHS through Fee-for-Service Medicaid

- Certain additional Mental Health Services (provided by state agencies)
- Dental Services (Under age 21)
- Dental Services (Over age 21) SCDHHS offers up to \$750 coverage annually for preventive and restorative dental services; Copay of \$3.40 per date of service is required
- Other Dental Services (age 21 and over) are covered for the following medical reasons:
 - Organ Transplant
 - Oncology Treatment
 - Total Joint Replacement
 - Heart Valve Replacement
- Non-Emergency Transportation
- Medicaid Adolescent Pregnancy Prevention Services (MAPPS)
- Developmental Evaluation Services (DECs)
- Targeted Care Management (TCM) Services
- Home and Community-Based Waiver Services

Services Not Covered

- Elective Cosmetic Surgery
- Custodial Care Services
- Elective Abortions
- Infertility Services

Prescription Drugs

Prescription drugs are covered through Molina. There is a Member co-pay of \$3.40 for prescriptions for Members age 19 and older. Pregnant women are exempt from any co-pays.

For additional information about the pharmacy benefit and its limitations, please contact the Pharmacy department at (855) 237-6178. A list of in-network pharmacies is available on the [MolinaHealthcare.com](https://www.molinahealthcare.com) website or by contacting Molina's Provider Services department at (855) 237-6178. An approval from Molina is required for some drugs. Some drugs are not covered. To see a list of covered drugs, check the Preferred Drug List (PDL). The PDL can change. It is important for Molina Members and Providers to check the PDL when medication needs to be filled or refilled. You can find a list of the preferred drugs at [MyMolina.com](https://www.mymolina.com) or [MolinaHealthcare.com](https://www.molinahealthcare.com).

Molina Members have access to an emergency supply of any medication written by their Provider, even if it has not been prior authorized. This includes specialty drugs. If a Provider prescribes an over-the-counter medication, Members will need a prescription in order to receive the drug.

Family planning services related to the injection or insertion of a contraceptive drug or device are covered.

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.

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 Health Care 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.

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 at (855) 882-3901. Molina's Nurse Advice Line is available 24 hours a day, seven days a week for mental health or substance abuse needs. The services Members receive will be confidential. Additionally, Members may access certain Behavioral Health Services directly through programs and services offered through the state of South Carolina including the Department of Mental Health (DMH) and the Department of Alcohol and Other Drug Abuse Services (DAODAS). (Molina is responsible for services provided through DAODAS).

Behavioral health services include:

- Inpatient Services (at an acute care hospital)
- Outpatient hospital services
- Psychiatric doctor services

These services may require Prior Authorization; see the Medical Management section of this Provider Manual for additional information.

Emergency Mental Health or Substance Abuse Services

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

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

Out of Area Emergencies

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

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

For out-of-area emergency care, plans will be made to transfer Members to an in-network facility when Member is stable.

Emergency and Ambulance 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.

Examples of conditions considered for emergency transports include, but are not limited to, acute and severe illnesses, untreated fractures, loss of consciousness, semi-consciousness, having a seizure or receiving CPR during transport, acute or severe injuries from auto accidents, and extensive burns.

Molina covers all transportation services provided via ambulance. These trips may be routine or non-routine, to a Medicaid covered service. Molina will provide stretcher trips as well as air ambulance or Medivac transportation.

Non-Emergency Medical Transportation

Molina does not provide non-emergency medical transportation. Non-emergency medical transportation is available to qualified individuals through the SCDHHS transportation broker system.

Medical non-ambulance transportation is defined as transportation of the beneficiary to or from a Medicaid covered service to receive medically necessary care. This transportation is only available to eligible beneficiaries who cannot obtain transportation on their own through other available means, such as family, friends or community resources. Molina will assist Members in obtaining medical transportation services through the SCDHHS transportation broker system as part of its care coordination responsibilities.

If one of your Members is in need of this service, please have them refer to the DHHS website for a listing of the transportation broker(s) and phone number(s). A listing is also available in the Appendix of this manual.

If your Member needs further assistance, they can also call Molina Member Services at (855) 882-3901 and one of our representatives will assist them.

Preventive Care

Preventive Care Guidelines are located on the Molina website. Please use the link below to access the most current guidelines. <https://www.MolinaHealthcare.com/providers/sc/medicaid/resource/prevent/prevent.aspx>

We need your help conducting these regular exams in order to meet the targeted State and Federal standards. If you have questions or suggestions related to well child care, please call our Health Education line at (855) 237-6178.

Molina understands the importance of preventive care and encourages all Members to schedule and keep primary care appointments so that overall health can be monitored. Molina expects Providers to deliver preventive care and encourage Molina Members to obtain services in accordance with preventive health guidelines for children, adolescents and adults.

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 and prescribed by the child's PCP.

Molina covers immunizations not covered through Vaccines for Children (VFC). The following is a list of immunizations required for children and adolescents.

Immunization	Ages
Hepatitis B (Hep B)	Birth, 1 – 2 months, and 6 – 18 months
Rotavirus (RV)	2 months, 4 months and 6 months
Diphtheria, Tetanus, Pertussis (DTaP)	2, 4, 6, 15 – 18 months and one between the ages of 4 – 6 years
Haemophilus influenza type b (HIB)	2, 4, 6 and 12 – 15 months
Pneumococcal (PCV)	2, 4, 6 and 12 – 15 months
Inactivated Poliovirus (IPV)	2, 4, 6 – 18 months and one between the ages 4 – 6 years
Influenza	6 months – 18 years, yearly (consult your PCP)
Measles, Mumps, Rubella (MMR)	12 – 15 months and one between the ages of 4 – 6 years
Varicella	12 – 15 months and one between the ages of 4 – 6 years
Hepatitis A (Hep A)	Two (2) doses between 12 – 24 months
Tetanus, Diphtheria, Pertussis (Tdap)	11 – 12 years
Human Papilloma Virus (HPV)	Three (3) doses between 11 – 12 years
Meningococcal (MCV)	One (1) dose between 11 – 12 years and one (1) dose at 16 years

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 mental 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 South Carolina recommended Centers for Disease Control and Prevention Advisory Committee on Immunization Practices Childhood Immunization Schedule, as appropriate.
- 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 mental illness or conditions discovered by the screening services.

We need your help conducting these regular exams in order to meet the South Carolina Department of Health and Human Services 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 contact your Provider Services representative.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	Infants (0-18) months	Children (2-6) years	Adolescents (7-21) years
Physical Exam and Health History	<ul style="list-style-type: none"> • History • Height • Weight • Physical exam • Oral Health • Body Mass Index (BMI) • Blood Pressure 	<ul style="list-style-type: none"> • History • Height • Weight • Physical exam • Oral Health • Body Mass Index (BMI) • Blood Pressure 	<ul style="list-style-type: none"> • History • Height • Weight • Physical exam • Oral Health • Body Mass Index (BMI) • Blood Pressure
Development and Behavior Assessment	<ul style="list-style-type: none"> • Gross motor • Fine motor • Social/emotional • Nutritional • (any one of these) 	<ul style="list-style-type: none"> • Gross motor • Fine motor • Communication • Self-help skills • Cognitive skills • Social/emotional • Regular physical activity • Nutritional (any one of these) 	<ul style="list-style-type: none"> • Social/emotional • Regular physical activity • Nutritional • (any one of these)
Mental Health Assessment	Mental health (must be addressed)	Mental health (must be addressed)	<ul style="list-style-type: none"> • Mental health • Substance abuse (either one of these)
Health Education/ Anticipatory Guidance	<ul style="list-style-type: none"> • Injury prevention • Passive smoking (either one of these) 	<ul style="list-style-type: none"> • Injury prevention • Passive smoking (either one of these) 	<ul style="list-style-type: none"> • Injury prevention • STD prevention • Smoking/tobacco (any one of these)
Health Reward Offered	✓	✓	✓

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

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

Nurse Advice Line

Members may call the Nurse Advice Line anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, 7 days a week, to assess symptoms and help make good health care decisions.

English Phone: (844) 800-5155

Spanish Phone: (866) 648-3537

TTY/TDD: 711 Relay

Molina is committed to helping our Members:

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

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

Health Management Programs

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: 711.

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

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 associates 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 ten 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.

Section 5. Provider Responsibilities

Non-discrimination of Health Care Service Delivery

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

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

Section 1557 Investigations

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

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

Toll Free: (866) 606-3889

TTY/TDD: 711

Online: <https://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: <https://www.federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority>

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). Providers are required to inform Molina's South Carolina Network Administration at SCNetworkAdministration@MolinaHealthcare.com if they are not ADA compliant or handicap accessible and provide what alternative accommodations are being offered to Members.

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. A Molina Member may request a printed copy of the Provider Directory at any time by contacting Member Services.

Providers must validate the Provider Online Directory (POD) information regularly 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 of a Provider (within an existing clinic/practice).
- Change in practice name, TaxID and/or National Provider Identifier (NPI).
- Opening or closing your practice to new patients (PCPs only).
- Any other information that may impact Member access to care.

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

Please visit our Provider Online Directory at [MolinaHealthcare.com](https://www.MolinaHealthcare.com) to validate your information. For corrections and updates, a convenient Provider change form can be found at <https://www.MolinaHealthcare.com/providers/sc/medicaid/forms/fuf.aspx>. Please email practice updates to MHSCPODValidation@MolinaHealthcare.com. You may also contact your Provider Services representative or (855) 237-6178 if your information needs to be updated or corrected.

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 its 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

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 <https://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: <https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index>.

Molina Electronic Solutions Participation

Molina encourages participating Providers to utilize electronic solutions and tools.

Molina encourages all contracted Providers to participate in and comply with Molina's Electronic Solution Requirements, which include, but are not limited to, electronic submission of Prior Authorization requests, Prior Authorization status inquiries, health plan access to electronic medical records (EMR) electronic Claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic Claims Appeal and registration for and use of the 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 encouraged to comply with Molina's Electronic Solution Policy by enrolling for EFT/ERA payments and registering for the 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.

Balance Billing

Providers contracted with Molina cannot bill the Member for any covered services beyond applicable copays, deductibles, or coinsurance. The Provider is responsible for verifying eligibility and obtaining approval for those services that require Prior Authorization.

Providers may not charge Members fees for covered services beyond copays, deductibles or coinsurance.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider. Balance billing a Molina Member for services covered by Molina is prohibited. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider for Medicaid covered services. Balance billing a Molina Member is prohibited.

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 copay, coinsurance and deductible amounts.

For additional information please refer to the Compliance and Claims and Compensation sections of this Provider Manual. Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider for Medicaid covered services. Balance billing a Molina Member is prohibited.

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:

- Electronic Claims Submission Options
- Electronic Payment EFT with ERA
- Provider Portal

Electronic Claims Submission Requirement

Molina strongly encourages participating Providers to submit Claims electronically. 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 enables Claims to reach Molina faster

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina of State via the Provider Portal. See the Provider Portal Quick Reference Guide at Provider.MolinaHealthcare.com or contact your Provider Services representative for registration and Claim submission guidance.
- Submit Claims to Molina through your EDI clearinghouse using Payer ID 46299, or refer to our website, MolinaHealthcare.com, 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 Claims submission, see the Claims and Compensation section of this Provider Manual.

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 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 process.

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

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 HEDIS needed services (gaps)
- Claims:
 - Submit Professional (CMS1500) and Institutional (UB04) Claims with attached files
 - Correct/void Claims
 - Add attachments to previously submitted Claims
 - Check Claims status
 - View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
 - Create and manage Claim templates
 - Create and submit a Claim appeal with attached files
- Prior Authorizations/Service Requests
 - Create and submit Prior Authorization/Service requests
 - Check status of authorization/service requests
- View HEDIS® Scores and compare to national benchmarks
- View a roster of assigned Molina Members for Primary Care Providers (PCP(s))
- Download forms and documents
- Send/receive secure messages to/from Molina

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

Member Information and Marketing

Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all State and Federal Laws and regulations and must be approved by Molina prior to use. Please contact your Provider Services representative for information and review of proposed materials.

Member Eligibility Verification

Possession of a Molina ID card does not guarantee Member eligibility or coverage. Providers should verify eligibility of Molina Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services. For additional information please refer to the Eligibility, Enrollment, Disenrollment and Grace Period section of this Provider Manual.

Member Cost Share

Providers should 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).

Health Care Services (Utilization Management and Care Management)

Providers are required to participate in and comply with Molina's Utilization Management (UM) and Care Management programs, including all policies and procedures regarding Molina's facility admission, Prior Authorization, and 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 Health Care Services section of this Provider Manual.

In-Office Laboratory Tests

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

Additional information regarding in-network laboratory Providers and in-network laboratory Provider patient service centers is found on the laboratory Providers' respective websites at <https://appointment.questdiagnostics.com/patient/confirmation> and <https://www.labcorp.com/labs-and-appointments>.

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

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

Referrals

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

Providers should direct 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. PCPs are able to refer a Member to an in-network specialist for consultation and treatment without a Prior Authorization.

For additional information, please refer to the Health Care 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.

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 Provider 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.

Pharmacy Program

Providers are required to adhere to Molina's Preferred Drug List and prescription policies. You can find a list of the preferred drugs at [MyMolina.com](https://www.molinahc.com/MyMolina.com) or [MolinaHealthcare.com](https://www.molinahc.com/MolinaHealthcare.com). For additional information please refer to the Pharmacy section of this Provider Manual.

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.

Compliance

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

Confidentiality of Member Health Information and HIPAA Transactions

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

Participation in Grievance and Appeals Programs

Providers are required to participate in Molina's Grievance Program and cooperate with Molina in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries. If a Member has a complaint regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member submits an appeal, the Provider will participate by providing medical records or statements if needed. This includes the maintenance and retention of Member records for a period of not less than 10 years for adult patients and at least 13 years for minors, and retained further if the records are under review or audit until such time that the review or audit is complete.

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

Participation in Credentialing

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

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

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

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.

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

Screening, Brief Intervention and Referral to Treatment (SBIRT)

Molina has partnered with SCDHHS, DAODAS, DHEC and DMH to expand and enhance state substance use identification and treatment for pregnant Members. Providers are encouraged to screen ALL pregnant women, to include up to 12 months postpartum, utilizing the SBIRT Integrated Screening Tool (form located in Appendix). Keep all completed screening tools in the patient's record and send copies to the referral resource and to Molina. Completed tools for Molina Members can be faxed to (866) 423-3889. Two codes can be billed in support of SBIRT services: H0002 (SBIRT behavioral health screening) and H0004 (SBIRT behavioral health brief intervention).

Relocations and Additional Sites

Providers should notify Molina 30 days in advance when they relocate or open an additional office, or a time frame as may be required by applicable State regulations, whichever is greater. When this notification is received, a site review of the new office may be conducted before the Provider's recredentialing date.

Section 6. Cultural Competency and Linguistic Services

Background

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency (LEP) and Members who are deaf, hard of hearing, non-verbal, have a speech impairment, or have an intellectual disability. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, genders, gender identities, sexual orientations, ages and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at MolinaHealthcare.com from your local Provider Services representative and by calling Molina Provider Services at (855) 237-6178.

Nondiscrimination of Health Care Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the 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 home pages. 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) the Office for Civil Rights (OCR), State law, and Federal program rules which prohibit discrimination. 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.

Additionally, Participating Providers or contracted medical groups/Independent Physician Associations (IPA) 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
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 <https://www.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 <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>.

If you or a Molina Member needs help, call (800) 368-1019; TTY (800) 537-7697.

Should you or a Molina Member need more information, you can refer to the Health and Human Services website at: <https://www.federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority>.

Cultural Competency

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

Provider and Community Training

Molina offers educational opportunities in cultural competency concepts for Providers, their staff, and Community Based Organizations. Molina conducts Provider training during Provider orientation with annual reinforcement training offered through Provider Services and/or online/web-based training modules.

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

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

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](https://www.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.

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; and,
 - Contracted Providers to assess gaps in network demographics.
- Revalidate data at least annually.
- Local geographic population demographics and trends derived from publicly available sources (Community Health Measures and State Rankings Report).
- Applicable national demographics and trends derived from publicly available sources.
- Assessment of Provider Network.
- Collection of data and reporting for the Diversity of Membership HEDIS® measure.
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations.
- Analysis of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Contact Center toll free at (855) 237-6178. If Contact Center representatives are unable to interpret in the requested language, the representative will immediately connect you and the Member to a qualified language service Provider.

Molina Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset.

Providers may offer Molina Members interpreter services if the Members do not request them on their own. Please remember it is never permissible to ask a family member, friend or minor to interpret.

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 Molina's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code and vendor.
- Document all counseling and treatment done using interpreter services.
- Document if a Member insists on using a family member, friend or minor as an interpreter, or refuses the use of interpreter services after notification of his or her right to have a qualified interpreter at no cost.

Members Who Are Deaf or Hard of Hearing

Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to Member & Provider Contact Center, Quality, Health Care Services and all other health plan functions.

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

Molina will provide face-to-face or video service delivery for ASL to support our Members who are deaf or hard of hearing. Requests should be made three business days in advance of an appointment to ensure availability of the service. In most cases, Members will have made this request via Molina Member Services.

Nurse Advice Line

Molina provides Nurse Advice services for Members 24 hours a day, seven days a week. The Nurse Advice Line provides access to 24-hour interpretive services. Members may call Molina's Nurse Advice Line directly - English line (844) 800-5155 or TTY/TDD 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

Section 7. Health Care Services (HCS)

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.

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; and
- 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.

Activity	Resource Management	Evaluation
Inpatient Admission Review	Eligibility verification Prior Authorization of planned elective admissions Urgent/Emergent inpatient admission	Utilization data analysis
Prior Authorization Review	Eligibility verification Benefit administration and interpretation. Verification of current Provider contract status Redirection of services to participating Providers Medical necessity review of requested services to meet Member need & benefit plan provisions	Utilization data analysis Geo-access analysis by Provider Contracting
Post-Service Claim Audits	Ensure authorized care meets Member need and benefit plan provisions	Utilization data analysis. Monitoring for over and under-utilization of clinical resources
Discharge Planning	Ensure safe and effective transition from inpatient or facility-based care to a lower level of care	Utilization data analysis, including hospital readmission rates
Transitions of Care	Coordinate and facilitate Immediate post-hospital discharge and service needs including follow-up appointments	Analyze re-admission data
Care Management	Manage Members with complex care needs and services. Ensures appropriate level of care and services is achieved for optional health outcomes	Monitor utilization data. Satisfaction of the Care Management process with quality surveys, Member and Provider input.
UM staff auditing and oversight	Staff education on consistent application of UM functions	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's website or contact the UM department.

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

UM Decisions

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

- Determination to authorize, provide or pay for services (favorable determination);
- Determination to delay, modify, or deny 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.

Providers can contact Molina's Health Care Services department at (855) 237-6178 to obtain Molina's UM Criteria.

Upon receipt of an adverse determination, the Provider (peer) may request a peer to peer discussion within three days of the decision for Prior Authorization requests. For inpatient admissions, a request for a peer to peer discussion may be granted as long as the Member is still in the facility.

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.

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

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

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

Medical Necessity

“Medically Necessary” or **“Medical Necessity”** means that a service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability (the provision of which may be limited by specific manual provisions, bulletins and/or other directives). These services furnished or ordered are

1. Necessary to protect life, to prevent significant illness or significant disability or alleviate severe pain
2. Individualized, specific and consistent with symptoms or confirm diagnosis or the illness or injury under treatment and not in excess of patient’s needs
3. Consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experiment or investigational
4. Reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide
5. Furnished in a manner not primarily intended for the convenience of the Member, the Members’ caretaker or the Provider.

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

MCG for Cite 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 for Cite 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.

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, as part of the Prior Authorization review for outpatient and elective inpatient review or retrospectively (under limited circumstances as deemed by Molina). 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 review articles and textbooks.

Levels of Administrative and Clinical Review

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

All UM requests that may lead to a medical necessity denial are reviewed by a health care professional at Molina (medical director, 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 the following:

1. physician emergency department notes,
2. inpatient history/physical exams,
3. discharge summaries,

4. physician progress notes,
5. physician office notes,
6. physician orders,
7. nursing notes,
8. results of laboratory or imaging studies,
9. therapy evaluations and therapist notes..

Molina does not accept clinical summaries, telephone summaries or inpatient care manager reviews as meeting the clinical information requirements unless State or Federal regulations allows such documentation to be acceptable.

Prior Authorization

Services that Require Prior Authorization

Molina requires Prior Authorization 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 or HCPCS codes and found on Molina's Provider Portal and website MolinaHealthcare.com. This includes a self-service authorization Look-Up Tool that allows a search by individual CPT and/or HCPCS codes to determine if Prior Authorization is necessary. This Look-Up Tool also provides useful information and rules around authorization of specific codes. Molina Prior Authorization documents are customarily updated quarterly but may be updated more frequently as appropriate or required by the SCDHHS, and are posted on the Molina website at MolinaHealthcare.com.

Prior Authorization Forms: Forms are located on the website and Providers are encouraged to submit Prior Authorization requests electronically. Additionally, Molina accepts the universal authorization forms located on the SCDHHS website under Reference Tools in the Managed Care Section.

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

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

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

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

Molina makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the Member's clinical situation.

Expedited/Urgent Prior Authorization Requests are defined when the situation where the standard time frame or decision-making process could seriously jeopardize the life or health of the Member, the health or safety of the Member or others, due to the Member's psychological state, or in the opinion of the Provider with knowledge of the Member's medical or behavioral health condition, would subject the Member to adverse health consequences without the care or treatment that is subject of the request or could jeopardize the Member's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

Timelines for UM Decisions

Type of Request	Defined	Determination Timeline	Notification
Standard Prior Authorization Request	Elective services and procedures	Decision made and notification provided within 14 calendar days	<p>Approvals, the Provider will receive an authorization number, by phone or fax.</p> <p>Denied services, the Provider will receive a faxed letter. Member will receive letter by mail.</p> <p>The letter will explain the reason for the denial and additional information regarding the grievance and appeals process.</p>

Type of Request	Defined	Determination Timeline	Notification
Expedited Prior Authorization Request	<p>Decisions where the Member's life or health may be jeopardized; or could jeopardize the Member's ability to regain maximum function.</p> <p>Providers must provide supporting documentation to justify an expedited authorization request. Without sufficient justification the authorization request may be downgraded and processed as a standard request</p>	Decision made and notification provided within seventy-two 72 hours or 3 calendar days from receipt of the request.	<p>Approvals, the Provider will receive an authorization number, by phone or fax.</p> <p>Denied services, the Provider will receive a faxed letter. Member will receive letter by mail.</p> <p>The letter will explain the reason for the denial and additional information regarding the grievance and appeals process.</p>

Peer-to-Peer Review

Upon receipt of an adverse determination, the Provider (peer) may request a peer-to-peer discussion within five business days of the decision for Prior Authorization requests. For inpatient admissions, a request for a peer-to-peer discussion may be granted within five business days from discharge.

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.

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](https://www.molinahealthcare.com) website:

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

Provider Portal: Participating Providers are encouraged to use the Provider Portal for Prior Authorization submissions whenever possible. Instructions for how to submit a Prior Authorization request are also available on the Provider Portal. The benefits of submitting your Prior Authorization request through the Provider Portal are:

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

Fax: The Prior Authorization Request Form can be faxed to Molina at: (866) 423-3889 and all Pharmacy requests can be faxed to (855) 571-3011.

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

Molina Healthcare of South Carolina
Attn: Health Care Services Dept.
PO Box 40309
North Charleston, SC 29423-0309

Open Communication about Treatment

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

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

Delegated Utilization Management Functions

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

Communication and Availability to Members and Providers

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 24 hours a day, seven days a week at (844) 800-5155. Molina's Nurse Advice Line may handle after-hours UM calls.

Services and/or Procedures That Require Prior Authorization

Molina has a list of services that require Prior Authorization located on the Provider Portal which can be reached at MolinaHealthcare.com. This list is searchable by unique CPT and HCPCS code and also provides information.

Emergency Services

Emergency Services means covered inpatient and outpatient services that are

- Furnished by a Provider that is qualified to furnish these services under this title; and
- Needed to evaluate or stabilize an Emergency Medical Condition

Emergency Medical Condition or Emergency means:

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 individual (or, with respect to a pregnant woman, the health of the woman and/or her 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 also provides Members a 24 hour Nurse Advice Line for medical advice. The 911 information is given to all Members at the onset of any call to the plan.

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

Molina 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.

Post Stabilization Services After Emergency Care

Post stabilization care services are covered services, whether inside or outside Molina's service area, that are related to an Emergency Medical Condition and provided after a Member is

stabilized in order to maintain the stabilized condition, or to improve or resolve the Member's condition until one of the following occurs:

- A. The Member is discharged; or
- B. A Molina participating physician with privileges at the treating hospital assumes responsibility for the Member's care; or
- C. A Molina participating physician assumes responsibility for the Member's care through transfer; or
- D. A Molina medical director and the treating physician reach an agreement concerning the Member's care.

Members who are admitted to the acute care facility then follow Molina's emergent inpatient admission process.

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 **24 hours of admission or by the following business day**. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning.

Molina requires that notification includes Member demographic information, facility information, date of admission and clinical information sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting admission notification, medical necessity requirements or failure to include all of the needed clinical documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient stay.

NOTE OB Deliveries: Normal deliveries not resulting in a Neonatal Intensive Care Unit (NICU) stay require notification only and must include the following:

- Baby's full name
- Baby's gender
- Baby's date of birth
- Type of birth (e.g. normal vaginal delivery or c-section)
- Newborn status (e.g. normal newborn or NICU admission)

Facilities are encouraged to submit their delivery admission discharge summary form or use Molina's Delivery Notification Form found on our website at <https://www.MolinaHealthcare.com/providers/sc/medicaid/forms/fuf.aspx>.

Observation Stay Converted to Inpatient Admission

Molina does NOT require authorization for Observation stays. However, if an Observation stay then converts to an Inpatient admission, Molina requires notification of that admission within ONE business day from the date the patient was made inpatient.

Example: Member was an Observation stay on Monday 1/13/2020 and converted to an inpatient admission on Wed 1/15/2020. Molina would require faxed notification of that inpatient admission no later than Thursday 1/16/2020.

IMPORTANT: Please submit clinical information that supports the reason(s) the Member transitioning from an Observation stay to an inpatient admit.

Calling Molina or submitting notification of the Observation stay does NOT serve as notification of the inpatient admission.

Untimely notification of such an inpatient admission will result in a denial of payment.

Observation does not require Prior Authorization; however, if the member did not originate in the Emergency Room, services rendered to members that require PA (such as Advanced Imaging) while in Observation are subject to the established Prior Authorization requirements.

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.

Inpatient/Concurrent Review

Molina performs concurrent inpatient review in order to ensure patient safety, medical necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. We have streamlined the process by increasing the time frame between admission and the next concurrent review date. Additionally, we only request current clinical information instead of daily notes. This will allow greater focus on monitoring patient progress and assisting with discharge planning. 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 any requested clinical information and updates be received by Molina from the inpatient facility within 24 hours of the request. Failure to provide timely clinical information updates will result in a 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 Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, medications, and disposition.

Inpatient Status Determinations

Molina's UM staff follow CMS guidelines to determine if the collected 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.

Discharge Planning

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

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

Readmissions

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

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

When a subsequent admission to the same participating hospital or facility is identified **within 30 calendar days from the date of discharge**, Molina's Medical Director will conduct a review of both stays to determine if the subsequent admission is in fact a readmission. There are two situations for Readmissions: Readmissions occurring within 24 hours from discharge (same or similar diagnosis); and Readmissions occurring within 2-30 days of discharge (same or similar diagnosis PLUS preventable).

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

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

- A Readmission is considered potentially preventable if it is clinically related to the prior admission and includes, but not limited to, the following circumstances:

- o Premature or inadequate discharge from the same hospital;
- o Issues with transition or coordination of care from the initial admission;
- o For an acute medical complication plausibly related to care that occurred during the initial admission.
- o The subsequent admission was due to a hospital acquired condition.

Post Service Review

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

Specific Federal or State requirements or Provider contracts that prohibit administrative denials supersede this policy.

Affirmative Statement about Incentives

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

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

Out of Network Providers and Services

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

Avoiding Conflict of Interest

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

Molina does not reward Providers or other individuals for issuing denials of coverage or care. Furthermore, Molina never provides financial incentives to encourage 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.

Coordination of Care and Services

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

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

Continuity of Care and Transition of Members

It is Molina's policy to provide Members with advance notice when a Provider they are seeing will no longer be in-network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the Provider(s) assuming care. 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 of 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 each Member identified in the categories above, Molina will work with the treating Provider on a transition plan over a reasonable period of time. Each case will be individualized to meet the Member's needs.

Requests for continued care should be submitted to Molina's Health Care Services Department via the address or fax listed at the beginning of this section. All requests for continuity of care will be reviewed by a Medical Director. Molina typically will not approve continued care by a non-participating Provider if:

- The Member only requires monitoring of a chronic condition
- The Provider does not qualify for Molina credentialing based on a previous professional review action

- The Provider is unwilling to continue care for the Member
- The Provider has never seen the Member prior to enrolling with Molina

For additional information regarding continuity of care and transition of Members, please contact Molina at (855) 237-6178.

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 to the South Carolina Department of Social Services at (888) CARE4US or (888) 227-3487, 24 hours a day/7 days a week.

South Carolina Department of Social Services
1535 Confederate Avenue
Columbia, SC 29201-1915

Client Services phone number (800) 616-1309.

Additionally, you may contact the National Child Abuse Hotline at (800) 422-4453 to report suspected child abuse as well.

Adult Abuse:

When there is concern that a Member is being abused, Molina's HCS teams will communicate with PCPs, Medical Groups/IPA, and delegated entities that one of your patients may be in this possible situation. All physicians, healthcare professionals, delegated entities, as well as Molina have a mandatory requirement, by law, to notify regulatory entities when adult and child abuse

is suspected. 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.

PCP Responsibilities in Care Management Referrals

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

Care Manager Responsibilities

The care manager collaborates with the Member and any additional participants as directed by the Member to develop a plan of care which includes a multidisciplinary action plan (care plan), a link to the appropriate institutional and community resources, and a statement of expected outcomes. Jointly, the care manager, and the Member are responsible for implementing the plan of care. Additionally, the care manager:

The CM program is individualized to accommodate the Member's needs. The Molina care manager will collaborate with the Member's Providers to arrange individual services for Members that may include coordination and continuity of medical care, home health care, rehabilitation services, and preventive services. The Molina care manager is responsible for the assessment of the Member and will communicate directly with the PCP regarding the Care Management Care Plan. The Member, PCP, and/or other Providers will also be invited to participate in Interdisciplinary Care Team meetings to ensure care coordination as well as continuity of care. If unable to participate, the care manager will communicate any recommendations from the meeting to the Member and Provider via telephone and written correspondence.

Referrals to Care Management: Members with high-risk medical conditions may be referred by their PCP or specialty care Provider to the CM program. The care manager works collaboratively with all Members of the health care team, including the PCP, hospital CM staff, discharge planners, specialist Providers, ancillary Providers, the local Health Department and other community resources. The referral source provides the care manager with demographic, health care and social data about the Member.

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

- Monitors and communicates the progress of the implemented plan of care to all involved resources

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

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 judgment 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, along with access to educational materials. You can also directly refer Members who may benefit from these program offerings by calling Molina's Provider Services department at (855) 237-6178 and selecting the option for "care management". Our Care Manager will help refer your patient to our Health Management team. 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
- Weight Management
- Smoking/Tobacco Cessation
- Substance Use Disorder
- Nutrition Consult

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

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.

Member Health Education Materials

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

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.

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; and
- Preventive Health Guidelines

Additional information on Health Management Programs is available from your local Molina Health Care Services department toll free at (855) 237-6178.

Primary Care Providers

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

Specialty Providers

Molina maintains a network of specialty Providers to care for its Members. Some specialty care Providers may require a referral for a Member to receive specialty services; however, no Prior Authorization is required. Members are allowed to directly access women health specialists for routine and preventive health without a referral for services.

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

Care Management (CM)

Molina provides a comprehensive CM program to all Members who meet the criteria for services. The CM program focuses on coordinating the care, services, and resources needed by Members throughout the continuum of care. Molina adheres to Care 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 the Care Management process. The CM program is based on a Member advocacy philosophy, designed and administered to assure the Member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes. The CM program is individualized to accommodate a Member's needs with collaboration 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 CM 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 CM 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 CM 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)
- Comorbid chronic illnesses (e.g. asthma, diabetes, COPD, 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
- Sickle Cell

Referrals to the CM program may be made by contacting Molina at (855) 237-6178

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; 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 Us. 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 us 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; 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.

We have 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.

This exclusion does not apply to services covered under “Approved Clinical Trials” in the “What is Covered Under My Plan?” section.

Section 8. Behavioral Health

Overview

Molina provides a Behavioral Health benefit for Members. Molina takes an integrated, collaborative approach to behavioral health care, encouraging participation from PCPs, behavioral health, and other specialty Providers to ensure whole person care. All provisions within the Provider Manual are applicable to medical and behavioral health Providers unless otherwise noted in this section.

Utilization Management and Prior Authorization

Behavioral Health inpatient and residential services can be requested by submitting a Prior Authorization form or contacting Molina's Prior Authorization team at (855) 237-6178. 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.

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.

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

Care Management

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

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

Phone: (855) 237-6178

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

Responsibilities of Behavioral Health Providers

Molina promotes collaboration with Providers and integration of 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 substance use disorder services to Molina Members. Behavioral Health Providers may only provide physical health care services if they are licensed to do so.

Providers shall follow Quality standards related to access. Molina provides oversight of Providers to ensure Members 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 days of the discharge date. If a Member misses a behavioral health appointment, the Behavioral Health Provider shall contact the Member within 24 hours of a missed appointment to reschedule.

Behavioral Health Crisis Line

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

Behavioral Health Tool Kit for Providers

Molina has developed an online Behavioral Health Tool Kit to provide support with screening, assessment, and diagnosis of common behavioral health conditions, plus access to Behavioral Health HEDIS® Tip Sheets and other evidence-based guidance, and recommendations for coordinating care. The material within this tool kit is applicable to Providers in both 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.

Section 9. Medical Management

Molina maintains a medical management program to ensure patient safety, ensure quality services are being provided as well as detect and prevent fraud, waste and abuse in its programs. The program ensures Molina only reimburses for services identified as a covered benefit that are medically necessary. Elements of the Molina medical management program include medical necessity review, Prior Authorization, inpatient management and review of the use of non-participating Providers.

This section on Referrals, Authorizations, and Health Care Services (Utilization Management) describes procedures that apply to directly contracted Molina Providers. All contracted Providers must obtain Molina’s authorization for specific services that require prior approval. Molina Providers must ensure Members receive medically necessary health care services in a timely manner without undue interruption. The Member’s PCP is responsible for:

- Providing routine medical care to Molina Members
- Following up on missed appointments
- Prescribing diagnostic and/or laboratory tests and procedures
- Coordinating Referrals and obtaining Prior Authorization when required

Referral Versus Prior Authorization

Referral: An authorization from Molina is not required to refer a patient to a participating specialist. In referring a patient, the PCP should forward pertinent patient information/findings to the Specialist.

Authorization: Generally, Prior Authorization requirements are designed to assure the medical necessity of service, prevent unanticipated denials of coverage, and ensure participating Providers are utilized and all services are provided at the appropriate level of care for the Member's needs.

Surgical Procedures

Molina does not provide additional reimbursement for the use of robotic equipment during surgical procedures.

How to Submit an Authorization Request

Providers should send requests for Prior Authorizations to the Molina Health Care Services Department. Authorization requests may be submitted via Molina's e-portal at MolinaHealthcare.com 24 hours/day, seven days/week. For the current version of the Prior Authorization Guide and Prior Authorization Request Form, please visit the Molina Provider Portal at MolinaHealthcare.com/Providers/sc/medicaid/forms/Pages/fuf.aspx. Prior Authorizations may also be submitted by fax, mail or in urgent situations by phone. Contact information is listed below:

Phone: (855) 237-6178 Fax: (866) 423-3889

Mail: Prior Authorization requests and supporting documentation can be submitted via U.S. mail at the following address: Molina Health Care of South Carolina

Attn: Health Care Services Dept.
PO Box 40309
North Charleston, SC 29423-0309

Emergency Care

A medical screening exam performed by licensed medical personnel in the emergency department and subsequent emergency care services rendered to the Member do not require Prior Authorization from Molina.

Members accessing the emergency department inappropriately will be contacted by Molina care managers whenever possible to 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.

Prior Authorization Decision Time Frames

Pursuant to South Carolina state-established time frames, Molina will process any non-urgent Prior Authorization requests no later than 14 calendar days following receipt of the request for service. Urgent requests will be processed as expeditiously as possible and within 72 hours of receipt of the request for service. A Molina Member can request up to 14 extra calendar days if he/she or the Provider needs to submit more information before Molina makes a decision. Molina can also request additional days if more information is needed to make a decision. For standard decisions Molina can request up to 14 extra calendar days, and if an expedited decision is needed Molina can request up to 48 extra hours. Molina will notify the Member in writing if an extension is needed.

Non-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 for Molina Members. Molina requires Members to receive medical care within the participating, contracted network of Providers. All care provided by non-contracted, non-network Providers must be prior authorized by Molina. Non-network Providers may provide emergent/urgent care 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.

Decision Making Process

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. Also, we require our delegated medical groups/IPAs to agree to the same process.

Section 10. Pharmacy

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. Molina's goal is to provide our Members with high quality, cost effective drug therapy. Molina works with our Providers and Pharmacists to ensure medications used to treat a variety of conditions and diseases are offered. Molina covers prescription and certain over-the-counter drugs.

Pharmacy and Therapeutics Committee

The National Pharmacy and Therapeutics Committee (P&T) meets quarterly to review and recommend medications for formulary consideration. The P&T Committee is organized to assist Molina with managing pharmacy resources and to improve the overall satisfaction of Molina Members and Providers. It seeks to ensure Molina Members receive appropriate and necessary medications. An annual pharmacy work plan governs all the activities of the committee. The committee voting membership consists of external physicians and pharmacists from various clinical specialties.

Pharmacy Network

Members must use their Molina ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, limitations, and network pharmacies is available by visiting MolinaHealthcare.com or calling Molina at (855) 882-3901.

Drug Formulary

The pharmacy program does not cover all medications. Molina keeps a list of drugs, devices, and supplies that are covered under the plan's pharmacy benefit. The list shows all the prescription and over-the-counter products Members can get from a pharmacy. Some medications require Prior Authorization (PA) or have limitations on age, dosage and/or quantities. For a complete list of covered medications please visit MolinaHealthcare.com.

Information on procedures to obtain these medications is described within this document and also available on the Molina website at [MolinaHealthcare.com](https://www.molinahealthcare.com).

Formulary Medications

In some cases, Members may only be able to receive certain quantities of medication. Information on limits are included and can be found in the formulary document.

Formulary medications with PA may require the use of first-line medications before they are approved.

Quantity Limitations

Quantity limitations have been placed on certain medications to ensure safe and appropriate use of the medication.

Age Limits

Some medications may have age limits. Age limits align with current U.S. Food and Drug Administration (FDA) alerts for the appropriate use of pharmaceuticals.

Step Therapy

Plan restrictions for certain drugs may require that other drugs be tried first. The Preferred Drug List (PDL) designates drugs that may process under the pharmacy benefit without Prior Authorization if the Member's pharmacy fill history with Molina shows other drugs have been tried for certain lengths of time. If the Member has trialed certain drugs prior to joining Molina, documentation in the clinical record can serve to satisfy requirements when submitted to Molina for review. Drug samples from Providers or manufacturers are not considered as meeting step therapy requirements or as justification for exception requests.

Non-Formulary Medications

Non-formulary medications may be considered for exception when formulary medications are not appropriate for a particular Member or have proven ineffective. Requests for formulary exceptions should be submitted using a Universal Medication Prior Authorization Request Form. Clinical evidence must be provided and is taken into account when evaluating the request to determine medical necessity. The use of manufacturer's samples of Non-Formulary or "Prior Authorization Required" medications does not override Preferred Drug List requirements.

Generic Substitution

Generic drugs should be dispensed when available. If the use of a particular brand name becomes medically necessary as determined by the Provider, PA must be obtained through the standard PA process.

New to Market Drugs

Newly approved drug products will not normally be placed on the formulary during their first six months on the market. During this period, access to these medications will be considered through the PA process.

Medications Not Covered

Medications not covered by Medicaid are excluded from coverage. For example, drugs used in the treatment of infertility or those used for cosmetic purposes are not part of the benefit.

Submitting a Prior Authorization Request

Molina will only process completed PA Request Forms. The following information **MUST** be included for the request form to be considered complete.

- Member first name, last name, date of birth and identification number
- Prescriber first name, last name, NPI, phone number and fax number
- Drug name, strength, quantity and directions of use
- Diagnosis

Molina's decisions are based upon the information included with the Universal Medication Prior Authorization request. Clinical notes are recommended. If clinical information and/or medical justification is missing Molina will either fax or call your office to request clinical information be sent in to complete the review. To avoid delays in decisions, be sure to complete the Universal Medication Prior Authorization Form in its entirety, including medical justification and/or supporting clinical notes.

Fax a completed Universal Medication Prior Authorization Form to Molina at (855) 571-3011. A blank Universal Medication Prior Authorization Form may be obtained by accessing MolinaHealthcare.com or by calling (855) 237-6178.

Member and Provider “Patient Safety Notifications”

Molina has a process to notify Members and Providers regarding a variety of safety issues which include voluntary recalls, FDA required recalls and drug withdrawals for patient safety reasons. This is also a requirement as an NCQA accredited organization.

Specialty Pharmaceuticals, Injectable and Infusion Services

Many specialty medications are covered by Molina through the pharmacy benefit using National Drug Codes (NDC) for billing and specialty pharmacy for dispensing to the Member or Provider. Some of these same medications may be covered through the medical benefit using Health Care Common Procedure Coding System (HCPCS) via paper or electronic medical Claim submission.

Molina, during the utilization management review process, will review the requested medication for the most cost-effective, yet clinically appropriate benefit (medical or pharmacy) of select specialty medications. All reviewers will first identify Member eligibility, any Federal or State regulatory requirements, and the Member specific benefit plan coverage prior to determination of benefit processing.

If it is determined to be a Pharmacy benefit, Molina's pharmacy vendor will coordinate with Molina and ship the prescription directly to your office or the Member's home. All packages are individually marked for each Member, and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies

(needles, syringes and alcohol swabs) with each prescription at no charge. Please contact your Provider Relations representative with any further questions about the program.

Newly FDA approved medications are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the Molina Pharmacy and Therapeutics Committee. “Buy-and-bill” drugs are pharmaceuticals which a Provider purchases and administers, and for which the Provider submits a Claim to Molina for reimbursement.

Pain Safety Initiative (PSI) Resources

Safe and appropriate opioid prescribing and utilization is a priority for all of us in health care. Molina requires Providers to adhere to Molina’s drug formularies and prescription policies designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to Members regarding Opioid and pain safety as needed.

Molina is dedicated to ensuring Providers are equipped with additional resources, which can be found on the Molina Provider website. Providers may access additional Opioid-safety and Substance Use Disorder resources at MolinaHealthcare.com under the Health Resource tab. Please consult with your Provider Services representative or reference the medication formulary for more information on Molina’s Pain Safety Initiatives.

Section 11. Quality

Maintaining Quality Improvement Processes and Programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement Program. You may contact the Molina Quality department toll free at (855) 237-6178.

The address for mail requests is:

Molina Healthcare of South Carolina
Quality Department
PO Box 40309
North Charleston, SC 29423-0309

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 representative or call the telephone number above to receive a written copy.

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

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

- Have a quality improvement program in place.
- Comply with and participate in Molina's Quality Improvement Program including reporting of Access and Availability Survey and activity results and provision of medical records as part of the HEDIS® review process and during Potential Quality of Care and/or Critical Incident investigations.
- Cooperate with Molina's quality improvement activities 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, service, and access and availability.
- Allow access to Molina QI personnel for site and medical record review processes.

Patient Safety Program

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

Quality of Care

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

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

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

Medical Records

Molina requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member's record. Molina annually conducts a review of member's medical records from a representative sample of Primary Care Practitioners (PCP) of the Molina provider network against

the medical record keeping standards and requirements as well as other providers as determined necessary. 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.

Practitioners/Providers must demonstrate compliance with Molina's medical record documentation guidelines. The provider is responsible to retain their records for at least ten years for adult patients and at least 13 years for minors. Medical records are assessed based on the following standards:

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 followup visits and referrals to other Providers.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Medication reconciliation within 30 days of an inpatient discharge should include evidence of current and discharge medication reconciliation and the date performed.
- Allergies and adverse reactions (or notation that none are known).
- Documentation that 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 followup 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.
- Uptodate 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 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 **toll free at (855) 237-6178**. For additional information regarding HIPAA please see the Compliance section of this Provider Manual.

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 percent availability for Emergency Services and 90 percent or greater for all other services. The PCP or their designee must be available 24 hours a day, seven days a week to Members.

Appointment Access

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

Primary Care Practitioner (PCP)	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Routine Primary Care	Within 4 weeks
Urgent Care	Within 48 hours
Emergent visits	Immediately upon referral
Urgent Medical Condition Care	Within 48 hours of referral or notification
Routine Specialist Care	Appointment time: within 12 weeks; Wait time: within 45 minutes
Emergency Care	Immediately upon presentation at treatment site. Access by telephone for emergent medical conditions.
Walk-in Patients	Should be seen if possible. Urgent needs must be seen within forty-eight hours of walk-in. Non-urgent needs must be seen within routine care guidelines above.
Office Wait Times	Within 45 minutes for a scheduled appointment of a routine nature
After-Hours Emergency Instructions	"If this is an emergency, please hang up and dial 911"
After-Hours Care	Available by phone 24 hours/seven days

Primary Care Practitioner (PCP)	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Behavioral Health	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Life Threatening Emergency	Immediately
Non-life Threatening Emergency	Within six hours of request
Urgent Care	Within 48 hours
Initial Routine Care Visit	Within 10 calendar days
Follow-up Routine Care Visit	Within 30 calendar days

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

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed 45 minutes. All PCPs are required to monitor waiting times and to adhere to this standard.

After Hours

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

Women's Health Access

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

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

Monitoring Access for Compliance with Standards

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

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

1. Provider access studies – Provider office assessment of appointment availability, after-hours access, Provider ratios and geographic access.
2. Member complaint data – assessment of Member complaints related to access and availability of care.

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.

Quality of Provider Office Sites

Molina Providers are to maintain office-site and medical record keeping practices standards. Molina continually monitors Member appeals/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 & 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, Blood-borne Pathogens, etc.) is documented for offices with 10 or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, and contracts, evidence of a hazardous waste management system in place.
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods.
- Confidential information is discussed away from patients.

When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.

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

Advance Directives (Patient Self-Determination Act)

Advance Directives

Practitioners/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. During routine Medical Record review, Molina auditors will look for document evidence of discussion between the practitioner/Provider and the Member. Molina will notify the Provider of an individual Member's advance directives identified through Care Management, care coordination or Care 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.

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

PCPs must discuss advance directives with a Member and provide appropriate medical advice if the Member desires guidance or assistance. Molina's network practitioners and facilities are expected to communicate any objections they may have to a Member directive prior to service whenever possible. In no event may any practitioner/Provider refuse to treat a Member or otherwise discriminate against a Member because the Member has completed an advance directive. Members have the right to file a grievance 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 practitioner/Provider fails to comply with advance directives instructions.

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

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

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

When There Is No Advance Directive: The Member's family and Provider will work together to decide on the best care for the Member based on information they may know about the Member's end-of-life plans. Providers must inform adult Molina Members, 18 years old and up, of their right to make health care decisions and execute Advance Directives. It is important that Members are informed about Advance Directives.

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, Evidence of Coverage (EOC) 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 are directed to the CaringInfo website at caringinfo.org/planning/advance-directives/ for forms available to download. Additionally, the Molina website offers information to both Providers and Members regarding advance directives, with a link to forms that can be downloaded and printed.

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

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

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

Molina will notify the Provider of an individual Member's Advance Directives identified through Care Management, Care Coordination or Care 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.

EPSDT Services to Members From Birth To Age Twenty-One (21) Years

Molina maintains monitoring mechanisms to ensure all required EPSDT services to Members from birth to age 21 years of age are timely according to required guidelines. All Members from birth to age 21 years of age should receive screening examinations including appropriate childhood immunizations at intervals as specified by the EPSDT Program as set forth in §§1902(a)(43) and 1905(a)(4)(B) of the Social Security Act and 89 Ill. Adm. Code 140.485. Children under three years of age, who are screened at-risk for, or with developmental delay, must be referred to SCDHHS's Early Intervention Program for further assessment. Molina's QI 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.

EPSDT Services to Members 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 Members under 21 years of age are timely according to required preventive guidelines. All Members under 21 years of age should receive preventive, diagnostic and treatment services at intervals as set forth in Section 1905(R) of the Social Security Act. Molina's Quality or the Provider Services department is also available to perform Provider training to ensure that best practice guidelines are followed in relation to well child services and care for acute and chronic health care needs.

Well-Child / Adolescent Visits

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

- Comprehensive health 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, as approved by SCDHHS.
- Vision and hearing tests.
- Dental assessment and services.
- Health education, including anticipatory guidance such as child development, healthy lifestyles, accident and disease prevention.
- Periodic objective screening for social, emotional, development using a recognized, standardized tool, as approved by SCDHHS.
- 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. If, as a result of EPSDT services, it is determined that the Member is in need of services that are not Covered Services but are services otherwise provided for under the SCDHHS Program, Molina will ensure that the Member is referred to an appropriate source of care. Molina shall have no obligation to pay for services that are not Covered Services.

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.

Health Management and Care Management

The Molina Health Management and Care Management Programs provide for the identification, assessment, stratification, and implementation of appropriate interventions for Members with chronic diseases.

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

Clinical Practice Guidelines

Molina adopts and disseminates Clinical Practice Guidelines (CPG) to Providers. 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's Clinical Practice Guidelines (CPG) are as follows:

- 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
- Sickle Cell Disease
- Schizophrenia
- Substance Abuse Treatment
- Suicide Risk
- Trauma-Informed Primary Care

The adopted CPGs are distributed and 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.

Preventive Health Guidelines

Molina provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF), Bright Futures/American Academy

of Pediatrics and Centers for Disease Control and Prevention (CDC), in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include, but are not limited to:

- Adult Preventive Services Recommendations
- 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](https://www.molinahealthcare.com) and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Cultural Competency Plan

Cultural Competency 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.

Measurement of Clinical and Service Quality

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

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

Molina evaluates continuous performance according to, or in comparison with objectives, measurable performance standards and benchmarks at the national, regional and/or at the local/health plan level. Contracted Providers and Facilities must allow Molina to use its performance data collected in accordance with the Provider's or facility's contract. The use of performance data may include, but is not limited to, the following: (1) development of Quality improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced Member cost sharing.

Molina's most recent results can be obtained from your local Molina Quality department or by visiting our website at [MolinaHealthcare.com](https://www.molinahealthcare.com).

Health Care 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, women's health screening, diabetes care, well check-ups, medication use, and cardio vascular disease.

HEDIS® results are used in a variety of ways. The results are the measurement standard form any 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.

Consumer Assessment of Health Care 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 a NCQA certified vendor.

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

Behavioral Health Satisfaction Assessment

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

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS® both focus on Member experience with health care Providers and health plans, Molina conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina, as this is one of the primary methods used to identify improvement areas pertaining to the Molina Provider Network. The survey results have helped establish improvement activities relating to Molina's specialty network, inter-Provider

communications, and pharmacy authorizations. This survey is fielded to a random sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of Quality Improvement Initiatives

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

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

Provider Profiling Program

Molina has developed a mechanism that evaluates and analyzes Provider performance based on meeting specific performance measures. Such measures include, but are not limited to, Withhold and HEDIS measures, medical record documentation, generic prescription rates and formulary compliance, and inpatient/emergency room utilization.

Providers who meet these quality and utilization management thresholds are referred by Molina to the Preferred Provider Program. This program provides a designation to the Provider and makes them eligible for increased Member assignment, reduction and simplification of the Prior Authorization process based on their quality recognition and ability to effectively manage care. All participating Providers are eligible for the Preferred Provider Program when criteria is met. Molina will inform Providers when they have been accepted into the program after reviewing and approving performance metrics and program eligibility requirements.

Providers approved for the Preferred Provider Program are subject to bi-annual analysis of quality and utilization management performance metrics to establish continued eligibility and participation in the program. Molina makes the final recommendation for a Provider's ongoing program participation.

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®/Qualified Health Plan Enrollee Experience survey Star Ratings measures, contact your local Molina Quality department.

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

Section 12. Risk Adjustment Management Program

What is Risk Adjustment?

The Centers for Medicare & Medicaid Services (CMS) defines Risk Adjustment as a process that helps accurately measure the health status of a plan's membership based on medical conditions and demographic information.

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

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 a Member. The visit may be face-to-face, or telehealth, depending on state or CMS requirements.
- Contain a treatment plan and progress notes.
- Contain the Member's name and date of service.
- Have the Provider's signature and credentials.

RADV Audits

As part of the regulatory process, State and/or Federal agencies may conduct Risk Adjustment Data Validation (RADV) audits to ensure 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 Services representative.

Section 13. Claims and Compensation

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 reasonably been prevented by the use of evidenced-based guidelines. CMS titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC and POA).

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

1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers
5. Falls and Trauma
 - a. Fractures
 - b. Dislocations
 - c. Intracranial Injuries
 - d. Crushing Injuries
 - e. Burn
 - f. Other Injuries

6. Manifestations of Poor Glycemic Control
 - a. Hypoglycemic Coma
 - b. Diabetic Ketoacidosis
 - c. Non-Ketotic Hyperosmolar Coma
 - d. Secondary Diabetes with Ketoacidosis
 - e. Secondary Diabetes with Hyperosmolality
7. Catheter-Associated Urinary Tract Infection (UTI)
8. Vascular Catheter-Associated Infection
9. Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
10. Surgical Site Infection Following Certain Orthopedic Procedures:
 - a. Spine
 - b. Neck
 - c. Shoulder
 - d. Elbow
11. Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
 - a. Laparoscopic Gastric Restrictive Surgery
 - b. Laparoscopic Gastric Bypass
 - c. Gastroenterostomy
12. Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
13. Iatrogenic Pneumothorax with Venous Catheterization
14. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
 - a. Total Knee Replacement
 - b. Hip Replacement

What this means to Providers:

- Acute IPPS Hospital Claims will be returned with no payment if the POA indicator is coded incorrectly or missing.
- 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:

<http://www.cms.hhs.gov/HospitalAcqCond/>.

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 through 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 46299.

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. The following information must be included on every Claim:

- Institutional Providers:
 - The completed UB 04 data set or its successor format adopted by the National Uniform Billing Committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC. Entries stated as mandatory by NUBC and required by federal statute and regulations and any state designated data requirements included in statutes or regulation.
- Physicians and Other Professional Providers:
 - The Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor or adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format. Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD) codes. Entries stated as mandatory by NUCC and required by federal statute and regulation and any state designated data requirements included in statutes or regulations. Participating Providers are required to submit Claims to Molina with appropriate documentation.

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, CPT or HCPCS for services or items provided
- Valid Diagnosis Pointers
- Total billed charges
- Place and type of service code
- Days or units as applicable
- 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
- Inpatient facility Claims require applicable condition, occurrence and value codes and applicable dates

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

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.

Electronic Claim Submission

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

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

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the Provider Portal.
- Submit Claims to Molina via your regular EDI clearinghouse using Payer ID 46299.

Provider Portal:

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

- Submit Professional (CMS1500) and Institutional (UB04) Claims with attached files.
- Correct/Void Claims.
- Add attachments to previously submitted Claims.
- Check Claims status.
- Create and manage Claim Templates.
- Create and submit a Claim Appeal with attached files.

Clearinghouse:

Molina uses Change Health Care as its gateway clearinghouse. Change Health Care has relationships with hundreds of other clearing houses. 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. In order to ensure that all data being submitted to our gateway is received properly your submitter must utilize the latest version of the 837 standard. It is important to track your electronic transmissions using your acknowledgment reports. The reports assure Claims are received for processing in a timely manner.

When your Claims are filed via a Clearinghouse

- You should receive a 999 acknowledgment from your clearinghouse.
- You should also receive 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.

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.

Paper Claim Submissions

If electronic submission is not possible, please submit paper Claims to the following address:

Molina Healthcare of South Carolina
PO Box 22664
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 Claims forms
- Paper Claims must be printed, using black ink.

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, 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 date of service of the Claim.

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

COB

Medicaid is the payer of last resort. 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 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 that coordination of benefits occurs, 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.

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 the 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.

Timely Claim Filing

The Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina, and shall include any and all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by Provider to Molina within 12 months/365 days after the discharge for inpatient services or the Date of Service for outpatient services; and Provider has been furnished with the correct name and address of the Member's health maintenance organization. If Molina is not the primary payer under coordination of benefits, Provider must submit Claims to Molina within 12 months/365 days from date of service after final determination by the primary payer. Except as otherwise provided by Law or provided by government sponsored program

requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment, and Provider hereby waives any right to payment.

Molina Coding Policies and Payment Policies

Frequently requested information on Molina's Coding Policies and Payment Policies is available on the [MolinaHealthcare.com](https://www.molinahealthcare.com) website under the Policies tab. Questions can be directed to your Provider Services representative.

Reimbursement Guidance and Payment Guidelines

Providers are responsible for 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 Health Care Common Procedure Coding System Level 1 (CPT codes), Level 2 and 3 (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 State and Federal requirements as well as administers payment rules based on generally accepted principles of correct coding. These rules include, but are not limited to, the following:

- Manuals and Relative Value Unit (RVU) files published by the Centers for Medicare & Medicaid Services (CMS), including:
 - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUE). In the event a State benefit limit is more stringent/restrictive than a Federal MUE, Molina will apply the State benefit limit. Further more, 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.

Telehealth Claims and Billing

Providers must follow CMS guidelines as well as State-level requirements.

All telehealth Claims for Molina Members must be submitted to Molina with correct codes for the plan type. Use the telehealth Place of Service (POS) Code 02, which certifies that the service meets the telehealth requirements. By coding and billing a place of service 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.

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 Health Care, Inc. uses NCCI standard payment methodologies.

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

General Coding Requirements

Correct coding is required to properly process 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.

Codes that are manually priced on the Medicaid Fee Schedule will be reimbursed at 35% of billed charges for covered benefits.

CPT and HCPCS Codes

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the AMA CPT and HCPCS codebooks. In order to ensure

proper and timely reimbursement, codes must be effective on the date of service (DOS) for which the procedure or service was rendered and not the date of submission.

Modifiers

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

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

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

ICD-10-CM/PCS codes

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

Place of Service (POS) Codes

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

Type of Bill

Type of bill is a four-digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC) Official 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)

For CPT codes that require an 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. If the CPT code requires an NDC and it is not submitted on the Claim, the Claim could deny.

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.

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 sample 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.

Corrected Claims

Corrected claims are considered new Claims for processing purposes. Corrected Claims may be submitted electronically with the appropriate field 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 Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P and include the original Claim number.

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

Paper corrected claims need to be marked as corrected and should be submitted to the following address:

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)
- In 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).

Timely Claim Processing

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider’s contract. Unless the Provider and Molina or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will process the claim for service within 30 calendar days after receipt of Clean Claims.

The receipt date of a claim is the date Molina receives either written or electronic notice of the claim.

Electronic Claim Payment

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

Overpayments and Incorrect Payments Refund Requests

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, it will make a Claim for such

Overpayment. Providers will receive an overpayment request letter if the overpayment is identified in accordance with State and CMS guidelines. Providers will be given the option to either:

1. Submit a refund to satisfy overpayment,
2. Submit request to offset from future claim payments, or
3. Dispute overpayment findings.

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 Over-payment 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 Over-payment.

Claim Disputes/Reconsiderations

Providers disputing a Claim previously adjudicated must request such action within 90 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 (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 reconsideration and must include the following documentation:

- 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.

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 30 business days of receipt of the Claims Dispute/Adjustment request.

Balance Billing

The Provider is responsible for verifying eligibility and obtaining approval for those services that require Prior Authorization.

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

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.

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 reporting, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS® reporting.

Encounter data must be submitted once per month, and must be submitted via HIPAA compliant transactions, including the ANSI X12N837I – Institutional, 837P – Professional, and 837D – Dental. Data must be submitted with Claims level detail for all non- institutional services provided.

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 acknowledgment of the transmission.
- Second, Molina will provide a 277CA response file for each transaction.

Section 14. Compliance

Fraud, Waste, and Abuse

Introduction

Molina is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Molina's Compliance department maintains a comprehensive plan, which is designed to address how 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 report findings to the appropriate regulatory and/or law enforcement agencies.

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 of fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false Claims.
- How Providers will detect and prevent fraud, waste, and abuse.
- Employee protection rights as a whistle blowers.

These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims acts. The whistle blower may also file a lawsuit independently. Cases found in favor of the government will result in the whistle blower receiving a portion of the amount awarded to the government.

Whistle blower 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 bear 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-Kick-back 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, under use, 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 of poor or inefficient billing methods (e.g. coding) causes 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 Members to health care facilities in which or with which the Provider has a financial relationship. (Stark Law)
- Altering Claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a Medicaid Member for Covered Services. This includes asking the Member to pay the difference between the discounted fees, 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.

Provider Profiling

Molina performs Claims audits to detect potential external health care fraud, waste, or abuse. These audits of Provider billings are based on objective and documented criteria. Molina uses a fraud,

waste, and abuse detection software application designed to score and profile Provider and Member billing behavior and patterns. The software utilizes a fraud finder engine to identify various billing behaviors, billing patterns, known schemes, as well as unknown patterns by taking into consideration a Provider or Member's prior billing history. The software statistically identifies what is expected based on prior history and specialty norms, including recognition of pattern changes from those identified in profiled historical paid Claims data and ongoing daily Claims batches. If a score reaches a certain parameter or threshold, the Provider or Member is placed on a list for further review.

Molina will inform the Provider of the billing irregularities and request an explanation of the billing practices. The Compliance department, with the aid of the Special Investigation Unit, may conduct further investigation and take action as needed.

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 charge back.

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.

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.

Medical Records

In accordance with your contract with Molina, which allows for the review of Claims, please submit **complete** medical records for all of the Members indicated for the dates of service provided. This includes, but is not limited to the following:

- Patient information sheets (completed by patient, parent, or guardian)
- Financial records including superbills, copays, copies of identification cards, and patient intake forms
- Provider orders
- Diagnostic test results
- Referral/authorization requests and forms
- Physician progress notes
- Medication records
- Graphic reports
- Emergency room records
- History and physical notes
- Operative reports
- Lab requisitions and lab reports

Please photocopy each record. Make sure all copies are complete and legible and contain both sides of each page, including page edges. Complete copies should include specific records to support the services provided and be separated by patient in chronological order.

All records should be sent via a trackable manner (e.g., certified mail). Please return a copy of the records request letter with the medical records to the following address:

Molina Healthcare, Inc.
Attn: Special Investigation Unit
200 Oceangate, Suite 100
Long Beach, CA 90802

Molina must be in receipt of the requested document within 15 calendar days from the receipt of this letter. Failure to submit requested documentation could result in the retrospective denial of Claims and other sanctions.

Provider Appeal Procedures

If you are in disagreement with any of the results of any audit conducted by the Special Investigation Unit at Molina, you have the right to file an appeal within 30 days from the date of the issued audit findings letter. In order for the appeal to be considered, the following must be enclosed:

- The written letter of appeal must be clearly labeled “Appeal Regarding SIU Audit Results;”
- A copy of the issued audit findings letter must be attached to the written letter of appeal;
- The written letter of appeal must contain all necessary information, such as the original Claim(s), medical record(s), Prior Authorization letter(s) or form(s), and any **new** information pertinent to the appeal, which **was not** originally submitted and/or reviewed by the SIU during the audit process.

Please send the written letter of appeal and supporting documentation to:

Molina Healthcare, Inc.
Attn: Special Investigation Unit
PO Box 22625
Long Beach, CA 90802

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.

Cooperating with Special Investigation Unit Activities

Molina Special Investigation Unit may conduct prepayment, concurrent, or post-payment review. Providers will cooperate with Special Investigation Unit activities, and will provide requested documentation to the unit following the timelines indicated in such requests. Failure to cooperate may result in further action, up to and including termination of the Provider contract.

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina Health Care Alert Line. Alert Line is an external telephone and web-based reporting system hosted by Global Compliance, a leading Provider of compliance and ethics hot line services. Alert Line telephone and web-based reporting is available 24 hours a day/seven days a week, 365 days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call Alert Line, a trained professional at Global Compliance 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 Alert Line can be made from anywhere within the United States with telephone or internet access.

Molina Alert Line 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 [MolinaHealth Care.AlertLine.com](https://MolinaHealthCare.AlertLine.com).

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

Molina Healthcare of South Carolina
Attn: Compliance
PO Box 40309
North Charleston, SC 29423-0309

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

South Carolina Department of Health and Human Services
Medicaid Fraud and Abuse Hotline
Toll Free Phone: (888) 364-3224
By Email: fraudres@scdhhs.gov
South Carolina Attorney General
Medicaid Fraud Unit
By Phone: (803) 734-3660 or Toll Free (888) 662-4325

HIPAA Requirements and Information

HIPAA (Health Insurance Portability & 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).

Provider Responsibilities

Molina expects that its contracted Provider 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 their PHI and includes a summary of how Molina safeguards their PHI.

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

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

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 State 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.

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity. Disclosure of PHI by one covered entity to another covered entity¹, 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 pre-authorization of services, concurrent review, and retrospective review of "services²."
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

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

- 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

Federal Confidentiality of Substance Use Disorder Patients Records regulations apply to any entity or individual providing Federally-assisted alcohol or drug abuse prevention treatment. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with substance use disorder treatment or programs are confidential and may 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 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 should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of 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.

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 its NPI to identify it on all electronic transactions required under HIPAA and on all Claims and Encounters (both electronic and paper formats) submitted to Molina.

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/Grievance
- Anti-Fraud Program Review
- Quality of Care Issues
- Regulatory Audits
- Risk Adjustment

- Treatment, Payment and/or Operation Purposes
- Collection of HEDIS® medical records

Business Continuity Plan (BCP)

The Provider will have a documented Business Continuity Plan (BCP) to ensure continuation and recovery of services after a disruption occurs. The BCP will be updated at least annually and approved by the applicable designated representative.

The Provider Business Continuity Plan will include:

- Names and contact information for staff responsible for invoking and managing response and recovery
- Molina notification names and contact information
- Disaster declaration process
- Details of how the services will be recovered and restored
- Details of how the systems and applications supporting the services will be recovered and restored, including recovery of data

The Provider will notify Molina of a disruption to the services or activation of business continuity plans within two hours and will provide Molina with regular updates on the situation and actions taken to resolve the issue, until normal services have been resumed.

The Provider will ensure that its third-parties needed to deliver the services have appropriate Business Continuity Plans in place to prevent significant disruption to the services.

The Provider will test the BCP at least annually and document the test results. Provider will make available to Molina, upon request. The results of the most recent test including lessons learned and remediation plans.

The Provider will participate in Molina annual tests upon notification and mutual agreement.

After disruption to services, once normal service has been resumed, the Provider will promptly complete a root cause analysis report and provide it to Molina.

Definitions

Business Continuity Plan: documented procedures that guide organizations to respond, recover, resume and restore to a pre-defined level of operations following a disruption.

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.

Section 15. Cybersecurity Requirements

Nonpublic Information Cybersecurity Attachment

Note: This section (Nonpublic Information Cybersecurity Attachment) is only applicable to Providers who are a delegated Provider and delegated 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 regulatory agency.
2. Provider shall implement appropriate administrative, technical, and physical measures to protect and secure the Information Systems and Nonpublic Information that are accessible to, or held by, the Provider.
3. Definitions:
 - i. “Cybersecurity Event” means an event resulting in unauthorized access to or the disruption or misuse of an information system or information stored on an information system. The term “Cybersecurity Event” does not include the unauthorized acquisition of encrypted nonpublic information if the encryption, process or key is not also acquired, released or used without authorization. The term “Cybersecurity Event” also does not include an event with regard to which Provider has determined that the nonpublic information accessed by an unauthorized person has not been used or released and has been returned or destroyed.
 - ii. “Information Systems” means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination or disposition of electronic 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.
 - iii. “Nonpublic Information” means information that is not publicly available information and is:
 - 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 which because of name, number, personal mark, or other identifier 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 or non driver 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 and that relates to:
 - 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.
- 4. Molina agrees to comply with all applicable laws governing Cybersecurity Events, including notification requirements. Molina will decide on further action including, but not limited to, notification to affected individuals or government entities. Upon Molina's prior written request, Molina agrees to assume responsibility for informing all such individuals 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 (with follow-up notification by mail) as promptly as possible, but in no event later than 72 hours from a determination that a Cybersecurity Event has occurred.

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 of South Carolina, Inc.
PO Box 40309
North Charleston, SC 29423-0309

- 6. Further, in the event of a Cybersecurity Event, Provider must provide Molina any documentation required by Molina to complete an investigation, or, upon written request by Molina, 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; and
 - 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 Nonpublic Information in Molina or Provider's possession, custody, or control.
- 7. Provider shall maintain records concerning all Cybersecurity Events for a period of at least five years from the date of the Cybersecurity Event or such longer period as required by applicable laws and produce those records upon demand of Molina.

8. In order for Molina to meet its reporting requirements pursuant to applicable law, Provider must notify Molina no later than 24 hours after determining that a Cybersecurity Event has occurred.
9. Provider must provide Molina the required information in electronic form as directed by Molina. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Molina concerning the Cybersecurity Event. The information provided to Molina must include at least the following:
 - 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 re-mediate the situation which permitted the Cybersecurity Event to occur;
 - l. a copy of Provider's privacy policy and a statement outlining the steps Provider will take to investigate and if requested by Molina, the steps that Provider will take to notify consumers affected by the Cybersecurity Event; and
 - m. the name of a contact person who is both familiar with the Cybersecurity Event and authorized to act on behalf of Provider.

Section 16. Credentialing and Recredentialing

The purpose of the Credentialing Program is to assure Molina Health Care and its subsidiaries (Molina) network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of Molina to provide superior health care to the community. Additional information is available in the Credentialing Policy and Procedure which can be requested by contacting your Molina Provider Services representative.

The decision to accept or deny a credentialing applicant is based upon primary source verification, secondary source verification and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under state and Federal Law.

The Credentialing Program has been developed in accordance with State and Federal requirements and the standards of the National Committee for Quality Assurance (NCQA) The Credentialing Program is reviewed annually, revised, and updated as needed.

Non-Discriminatory Credentialing and Re-credentialing

Molina does not make credentialing and re-credentialing decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation, ancestry, religion, marital status, health status, or patient types (e.g. Medicaid) in which the practitioner specializes. This does not preclude Molina from including in its network practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of Members.

Type of Practitioners Credentialed & Re-credentialed

Practitioners and groups of practitioners with whom Molina contracts must be credentialed prior to the contract being implemented.

Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral Health Care practitioners who are licensed, certified or registered by the state to practice independently
- Chiropractors
- Clinical Social Workers
- Dentists
- Doctoral or master's level psychologists
- Licensed/Certified Midwives (Non-Nurse)
- Master's-level clinical social workers
- Master's-level clinical nurse specialists or psychiatric nurse practitioners

- Medical Doctors (MD)
- Naturopathic Physicians
- Nurse Midwives
- *Nurse Practitioners
- Occupational Therapists
- Optometrists
- Oral Surgeons
- Osteopathic Physicians (DO)
- Pharmacists
- Physical Therapists
- **Physician Assistants
- Podiatrists
- Psychiatrists and other physicians
- Speech and Language Pathologists
- Telemedicine Practitioners

Credentialing Turn-Around Time

Molina fully enrolls/on-boards initial practitioners within sixty (60) calendar days. The sixty (60) calendar days is measured by the number days between the day Molina receives a full and complete credentialing application and the day the Agency successfully receives the practitioner on Molina's Provider Network Verification (PNV) file. Molina will submit the date it receives a full and complete credentialing application to the Agency on the PNV file requested.

Molina shall take into account and make allowances for the time required to request and obtain primary source verifications and other information that must be obtained from third parties in order to authenticate the practitioner's credentials and shall make allowances for the scheduling of a final decision to meet the sixty (60) day turnaround time.

Criteria for Participation in the Molina Network

Molina has established criteria and the sources used to verify these criteria for the evaluation and selection of practitioners for participation in the Molina network. These criteria have been designed to assess a practitioner's ability to deliver care. This policy defines the criteria that are applied to applicants for initial participation, re-credentialing and ongoing participation in the Molina network.

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

Molina reserves the right to exercise discretion in applying any criteria and to exclude practitioners who do not meet the criteria. Molina may, after considering the recommendations

of the Professional Review Committee, waive any of the requirements for network participation established pursuant to these policies for good cause, if it is determined such waiver is necessary to meet the needs of Molina and the community it serves. The refusal of Molina to waive any requirement shall not entitle any Provider to a hearing or any other rights of review.

Practitioners must meet the following criteria to be eligible to participate in the Molina network. The practitioner shall have the burden of producing adequate information to prove they meet all criteria for initial participation and continued participation in the Molina network. If the Practitioner fails provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina network. Practitioners who fail to provide proof of meeting these criteria do not have the right to submit an appeal.

- **Application** - Provider must submit to Molina a complete credentialing application either from CAQH Pro View or other State mandated practitioner application. The attestation must be signed within one-hundred-twenty (120) days. Application must include all required attachments.
- **License, Certification or Registration** - Provider must hold a current and, valid and license, certification or registration to practice in their specialty in every State in which they will provide care and/or render services for Molina Members. Telemedicine practitioners are required to be licensed in the State where they are located and the State the Member is located.
- **DEA or CDS Certificate** - Provider must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Provider must have a DEA or CDS in every State where the Provider provides care to Molina Members. If a practitioner has never had any disciplinary action taken related to their DEA and/or CDS and has a pending DEA/CDS certificate or chooses not to have a DEA and/or CDS certificate, the practitioner must then provide a documented process that allows another practitioner with a valid DEA and/or CDS certificate to write all prescriptions requiring a DEA number. If a practitioner does not have a DEA or CDS because it has been revoked, restricted or relinquished due to disciplinary reasons, the practitioner is not eligible to participate in the Molina network.
- **Specialty** - Provider must only be credentialed in the specialty in which they have adequate education and training. Provider must confine their practice to their credentialed area of practice when providing services to Molina Members.
- **Education** - Practitioner must have graduated from an accredited school with a degree in their designated specialty.
 - **Residency Training** - Practitioners must have satisfactorily completed a residency program from an accredited training program in the specialties in which they are practicing. Molina only recognizes residency training programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral

and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, podiatric residencies are required to be three years in length. If the podiatrist has not completed a three year residency or is not board certified, the podiatrist must have five years of work history practicing podiatry.

- o **Fellowship Training** – If the practitioner is not board certified in the specialty in which they practice and has not completed a residency program in the specialty in which they practice, they must have completed a fellowship program from an accredited training program in the specialty in which they are practicing.
- **Board Certification** – Board certification in the specialty in which the practitioner is practicing but not required. Initial applicants who are not board certified will be considered for participation if they have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing. Molina recognizes board certification only from the following Boards:
 - o American Board of Physicians
 - o American Board of Medical Specialties (ABMS)
 - o American Osteopathic Association (AOA)
 - o American Board of Foot and Ankle Surgery (ABFAS)
 - o American Board of Podiatric Medicine (ABPM)
 - o American Board of Oral and Maxillofacial Surgery
 - o College of Family Physicians of Canada (CFPC)
 - o Royal College of Physicians and Surgeons of Canada (RCPSC)
 - o Behavioral Analyst Certification Board (BACB)
 - o National Commission on Certification of Physician Assistants (NCCPA)
- **General Practitioners** – Practitioners who are not board certified and have not completed a training program from an accredited training program are only eligible to be considered for participation as a general practitioner in the Molina network. To be eligible, the practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history. Molina will consider allowing a practitioner who is/was board certified and/or residency trained in a specialty other than primary care to participate as a general practitioner, if the practitioner is applying to participate as a Primary Care Physician (PCP), Urgent Care or Wound Care. General practitioners providing only wound care services do not require five years of work history as a PCP.
- **Nurse Practitioners & Physician Assistants** – In certain circumstances, Molina may credential a practitioner who is not licensed to practice independently. In these instances, it would also be required that the practitioner providing the supervision and/or oversight be contracted and credentialed with Molina.

- **Work History** – Practitioner must supply most recent five years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six months, the practitioner must clarify the gap verbally or in writing. The organization documents a verbal clarification in the practitioner's credentialing file. If the gap in employment exceeds one year, the practitioner must clarify the gap in writing.
- **Malpractice History** – Practitioner must supply a history of malpractice and professional liability Claims and settlement history in accordance with the application.
- **Professional Liability Insurance** – Provider must supply a history of malpractice and professional liability Claims and settlement history in accordance with the application. Documentation of malpractice and professional liability Claims, and settlement history is requested from the practitioner on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.
- **State Sanctions, Restrictions on Licensure or Limitations on Scope of Practice** – Practitioner must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Practitioner must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner. Molina will also verify all licenses, certifications and registrations in every state where the practitioner has practiced. At the time of initial application, the practitioner must not have any pending or open investigations from any state or governmental professional disciplinary body. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.
- **Medicare, Medicaid and other Sanctions and Exclusions** – Practitioner must not be currently sanctioned, excluded, expelled or suspended from any state or federally funded program including but not limited to the Medicare or Medicaid programs. Practitioner must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner. Practitioner must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving federal contracts, certain subcontracts,

³ If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

and certain federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.

- o **Medicare Opt Out** – Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- o **Social Security Administration Death Master File** – Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.
- o **Medicare Preclusion List** – Practitioners currently listed on the Preclusion List may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- o **Professional Liability Insurance** – Practitioner must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the Practitioner's activities on Molina's behalf. Practitioners maintaining coverage under a federal tort or self-insured are not required to include amounts of coverage on their application for professional or medical malpractice insurance.
- o **Inability to Perform** – Practitioners must disclose any inability to perform essential functions of a practitioner in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.
- o **Lack of Present Illegal Drug Use** – Practitioner must disclose if they are currently using any illegal drugs/substances.
- o **Criminal Convictions** – Practitioners must disclose if they have ever had any criminal convictions. Practitioners must not have been convicted of a felony or pled guilty to a felony for a health care related crime including but not limited to health care fraud, patient abuse and the unlawful manufacturing, distribution or dispensing of a controlled substance.
- o **Loss or Limitations of Clinical Privileges** – At initial credentialing, Practitioner must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner. At re-credentialing, Practitioner must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the practitioner has had privileges since the previous credentialing cycle.
- **Hospital Privileges** – Practitioners must list all current hospital privileges on their credentialing application. If the practitioner has current privileges, they must be in good standing.
- **NPI** – Practitioner must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS).

Notification of Discrepancies in Credentialing Information & Practitioner's Right to Correct Erroneous Information

Molina will notify the practitioner immediately in writing in the event that credentialing information obtained from other sources varies substantially from that submitted by the practitioner. Examples include but are not limited to actions on a license, malpractice Claims history, board certification, sanctions or exclusions. Molina is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by Law. Practitioners have the right to correct erroneous information in their credentials files. Practitioner's rights are published on the Molina website and are included in this Provider Manual.

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

- Their requirement to submit a written response within ten calendar days of receiving notification from Molina
- In their response, the practitioner must explain the discrepancy, may correct any erroneous information and may provide any proof that is available
- The practitioner response must be sent to Molina Health Care, Inc. Attention: Credentialing Director at PO Box 2470 Spokane, WA 99210

Upon receipt of notification from the practitioner, Molina will document receipt of the information in the practitioner's credentials file. Molina will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with the practitioner's information, the Credentialing department will notify the practitioner.

If the practitioner does not respond within ten calendar days, their application processing will be discontinued and network participation will be administratively denied or terminated.

Practitioner's Right to Review Information Submitted to Support Their Credentialing Application

Practitioners have the right to review their credentials file at any time. Practitioner's rights are published on the Molina website and are included in this Provider Manual.

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

The only items in the file that may be copied by the practitioner are documents, which the practitioner sent to Molina (e.g., the application and any other attachments submitted with the application from the Practitioner). Practitioners may not copy any other documents from the credentialing file.

Practitioner's Right to be Informed of Application Status

Practitioners have a right, upon request, to be informed of the status of their application by telephone, email or mail. Practitioner's rights are published on the Molina website and are included in this Provider Manual. Molina will respond to the request within two working days. Molina will share with the practitioner where the application is in the credentialing process and note any missing information or information not yet verified.

Notification of Credentialing Decisions

Initial credentialing decisions are communicated to practitioners via letter or email. This notification is typically sent by the Molina Medical Director within two weeks of the decision. Under no circumstance will notifications letters be sent to the practitioners later than sixty (60) calendar days from the decision. Notification of re-credentialing approvals are not required.

Re-credentialing

Molina re-credentials every practitioner at least every 36 months.

Excluded Providers

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

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

Ongoing Monitoring of Sanctions

Molina monitors the following agencies for Provider sanctions and exclusions between re-credentialing cycles for all Provider types and takes appropriate action against Providers when occurrences of poor quality are identified. If a Molina Provider is found to be sanctioned or excluded, the Provider's contract will immediately be terminated effective the same date as the sanction or exclusion was implemented.

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program** - Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.

- **State Medicaid Exclusions** – Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent).
- **Medicare Exclusion Database (MED)** – Molina monitors for Medicare exclusions through the Centers for Medicare & Medicaid Services (CMS) MED online application site.
- **Medicare Preclusion List** – Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- **National Practitioner Database** – Molina enrolls all credentialed practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- **System for Award Management (SAM)** – Monitor for Providers sanctioned with SAM.

Molina also monitors the following for all Provider types between the re-credentialing cycles:

- Member Complaints/Grievances
- Adverse Events
- Medicare Opt Out
- Social Security Administration Death Master File

Provider Appeal Rights

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

Section 17. 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.

Disease Management

To be considered as a delegate for Disease Management functions, Medical Groups, IPAs and/or Vendors must meet the following criteria:

- Submit a written request to Molina to be considered for delegation.
- Be certified by the National Committee for Quality Assurance (NCQA) for complex Care Management and disease management programs.
- Must be able to support South Carolina Department of Health and Human Services (SCDHHS) disease management requirements that includes, but is not limited to, the following:
 - Comply with physical and behavioral health Disease Management and Care Management /Coordination provisions
 - Preventive and Rehabilitative Services for Primary Care Enhancement
 - Develop utilization review protocols-utilization review falls under the scope of UM Delegation
 - Consult with the Department prior to implementation of the Contractor's protocols to ensure alignment with the intent of this service
- Monthly Disease Management Reporting Requirements
 - Submit a monthly report of all Members that are receiving disease management services.

- Member program eligibility and enrollment data, program engagement rates, and maintenance of NCQA compliant disease management care plans
- Quarterly program performance reporting
- Undergo a delegation pre-assessment audit. The audit includes the following standards:
 - Verification of NCQA certification
 - Assess program compliance for meeting South Carolina Department of Health and Human Services (SCDHHS) contractual requirements for disease management
- Honors timely requests for disease management files required for internal and external audits
- Comply with all applicable federal and state laws

Note: Molina does not allow disease management delegates to further sub-delegate disease management activities.

A Medical Group, IPA, or Vendor interested in a delegated Disease Management arrangement should contact Molina's Quality Improvement Compliance Department.

Credentialing

Credentialing functions may be delegated to Capitated or Non-Capitated entities, which meet National Committee for Quality Assurance (NCQA) criteria for credentialing functions. To be delegated for credentialing functions, Providers must:

- Pass Molina's credentialing pre-assessment, which is based on NCQA credentialing standards.
- Have a multi-disciplinary Credentialing Committee who is responsible for review and approval or denial/termination of practitioners included in delegation.
- Have an Ongoing Monitoring process in place that screens all practitioners included in delegation against OIG and SAM exclusion lists a minimum of every 30 days.
- Correct deficiencies within mutually agreed upon time frames when issues of non-compliance are identified by Molina.
- Agree to Molina's contract terms and conditions for credentialing delegates.
- Submit timely and complete Credentialing delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Comply with all applicable federal and state Laws.
- When key specialists, as defined by Molina, contracted with IPA or group terminate, provide Molina with a letter of termination according to Contractual Agreements and the information necessary to notify affected Members.
- Must employ a minimum of 100 practitioners.
- Must have an NCQA compliant credentialing process that has been in operation for at least three years.

Note: If the Provider is an NCQA Certified or Accredited organization, a modified pre-assessment audit may be conducted. Modifications to the audit depend on the type of Certification or Accreditation the Medical Group, IPA, or Vendor has, but will always include evaluation of applicable state requirements and Molina business needs.

If the Provider sub-delegates Credentialing functions, the sub-delegate must be NCQA accredited or certified in Credentialing functions or demonstrate an ability to meet all Health Plan, NCQA, and State and Federal requirements identified above. A written request must be made to Molina prior to execution of a contract, and a pre-assessment must be completed on the potential sub-delegate, and annually thereafter. Evaluation should include review of Credentialing policies and procedures, Credentialing and Re-credentialing files Credentialing Committee Minutes, Ongoing Monitoring documentation, and a process to implement corrective action if issues of non-compliance are identified.

An entity may request Credentialing delegation from Molina through Molina's Delegation Oversight Manager or through their Contract Manager. Molina will ask the potential delegate to submit a Credentialing Pre Delegation survey, policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate Credentialing responsibilities is based on the entity's ability to meet Molina, State and Federal requirements for delegation.

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 Contract Manager.

Section 18. Appeals and Grievance Process

Molina Members or Members' personal representatives have the right to file a grievance and submit an appeal through a formal process. All grievances and appeals must first be submitted to Molina for resolution. Members also have access to the State Fair Hearing system if they are dissatisfied with Molina's final determination of an appeal.

Molina Members and Providers will not be penalized, discriminated against or otherwise retaliated against for filing a grievance or appeal. Members are informed of their grievance and appeal rights and their access to the State Fair Hearing system (for appeals) through various general communications including, but not limited to, the Member Handbook, and Disclosure, Member Newsletters and Molina's website: MolinaHealthcare.com.

This section addresses the identification, review and resolution of Member grievances and appeals. Below is Molina's Member Grievance and Appeals Process.

Definitions

Adverse Benefit Determination: Adverse benefit determination means the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner; the failure to act within the time frames provided in State and Federal regulations regarding the standard resolution of grievances and appeals; for a resident of a rural area with only one MCO, the denial of a Member's request to exercise his or her right to get services outside the Molina network; or the denial of a Member's request to dispute a financial liability, including cost sharing, copays, premiums, deductibles, coinsurance, and other Member financial liabilities.

Appeal: An appeal is a request for Molina to review an adverse benefit determination/decision made.

Clinical Peer: Clinical peer means a health care professional who is in the same profession and the same or similar specialty as the health care Provider who typically manages the medical condition, procedures, or treatment under review.

Expedited Appeal: An Expedited Appeal is a request for Molina to review an adverse benefit determination where the adverse benefit determination is related to a hospital admission, continued stay, or other health care services, when following the standard appeals time frame could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

Grievance: Grievance means any expression of dissatisfaction about a matter other than an adverse benefit determination. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, aspects of personal relationships such as rudeness of a Provider or employee or failure to respect a Member's rights.

Second Opinion

If a Member or Member's authorized representative does not agree with their Provider's plan of care, they have the right to request a second opinion from another Provider. Members can call Member Services to find out how to get a second opinion, and under what circumstances a second option can be obtained/approved. If a Member receives services from an out-of-network Provider then prior approval will be required.

Providers may also request a second opinion for a Member if certain clinical requirements are met. Providers should call Provider Services for additional information regarding Molina's Second Opinion Policy.

Member Grievance Process:

If a Member is unhappy with the service from Molina or Providers contracted with Molina, they may file a grievance by contacting Member Services toll-free at (855) 882-3901. They can also write to us at:

Molina Healthcare of South Carolina
Attn: Member Appeals & Grievances
PO Box 40309
North Charleston, SC 29423-0309
Or via fax: (877) 823-5961

All grievances, whether oral or written, are documented and logged in all appropriate systems. Members may identify an individual in writing, including an attorney or Provider, to serve as a personal representative to act on their behalf at any stage during the grievance and appeals process. If under applicable law, a person has authority to act on behalf of a Member in making decision related to health care or is a legal representative of the Member, Molina will treat such person as a personal representative. The Member (or authorized representative) shall have the right to participate in the formal grievance proceedings.

When needed, Members are given reasonable assistance in completing forms and taking other procedural steps, including translation services for Members with limited English proficiency or other limitations, e.g., hearing impaired, requiring communication support.

Molina does not discriminate against, retaliate against, or take any other form of punitive action against Members or Members' representatives for utilizing the grievance process. Molina does not take punitive action of any kind against Providers for assisting Members in the grievance process.

Any grievance regarding a potential quality of care issue is referred to the Quality Improvement Department for further investigation. Additionally, any identified issue related to the Privacy and Confidentiality of Protected Health Information (PHI) is referred to the Compliance department.

Molina has an organized grievance process to ensure thorough, appropriate and timely resolution to Member grievances. Grievance analysis is performed regularly to identify trends, concerns and opportunities for improvement.

Grievance Timelines

Grievances may be filed orally or in writing at any time from the date the Member became aware of an issue. Oral grievances are acknowledged at the time of filing and written acknowledgment is issued within five business days for grievances filed in writing. Grievances may be submitted by Members, a Member's Provider (with the Member's consent) or Member's authorized representative acting on behalf of the Member with written consent from the Member.

All grievances are resolved within 90 calendar days.

A Member can ask Molina to extend the time frame to resolve a grievance by up to 14 calendar days. Molina can also extend the time frame to resolve a grievance by up to 14 calendar days if Molina thinks that the delay is in the Member's best interest. If Molina extends the time frame, we must be able to explain to SCDHHS how the delay is in the Member's best interest. We will call the Member and a letter will be sent to the Member informing him or her of the extension and why the delay is in their best interest. If Molina extends the time frame, the letter will also include information about the Member's right to file a grievance about extending the time frame.

Appeals

An appeal is a request for Molina to review an adverse benefit determination/decision made regarding a request for services including the type, level, and duration of services. Appeals may be submitted by Members, Providers or their authorized representative acting on behalf of the Member with written consent from the Member. A Provider can appeal on a Molina Member's behalf if the Member has agreed to treatment; Molina has received medical records from the Provider; and/or there is a history of paid Claims for services from the Provider. When a requested health care service has been denied in whole or part, the Members are sent a notice of the denied adverse benefit determination. The following is included in the notice:

- Their right to appeal the decision
- The process by which the appeal is initiated
- The Molina Customer Service phone number where more information regarding the appeal process can be obtained
- The availability of Molina to assist the Member in filing an appeal if needed

All appeals that involve a denial based on clinical medical necessity will be reviewed by the Chief Medical Officer (CMO)/Medical Director who was not involved in any previous level of review or decision-making and has the appropriate clinical expertise. When appropriate, appeals will be sent out for an independent review to ensure it meets the NCQA guidelines of a clinical review by a "same or similar" specialty. A written appeal resolution letter will contain reasons for the determination including the medical or clinical criteria for the determination. The letter will also provide the Member with their State Fair Hearing rights if the denial is upheld.

A Member can ask Molina to extend the time frame to resolve an appeal by up to 14 calendar days. Molina can also extend the time frame to resolve an appeal by up to 14 calendar days if Molina thinks that the delay is in the Member's best interest. If Molina extends the time frame,

we must be able to explain to SCDHHS how the delay is in the Member's best interest. We will call the Member and a letter will be sent to the Member informing him or her of the extension and why the delay is in their best interest. If Molina extends the time frame, the letter will also include information about the Member's right to file a grievance about extending the time frame.

Members who are not satisfied with Molina's appeal determination may request a State Fair Hearing. A State Fair Hearing must be requested within 120 calendar days of the date on the notice of Appeal resolution.

Standard Appeals Process and Timeline

Standard appeals may be submitted orally or in writing. Oral appeals must be followed by a written appeal request. Standard appeals must be filed within 60 calendar days from the date of the notice of adverse benefit determination and may be submitted to:

Molina Healthcare of South Carolina
Attn: Member Appeals & Grievances
PO Box 40309
North Charleston, SC 29423-0309
Or
Via Fax: (877) 823-5961
Or
Via Phone: (855) 882-3901

Molina will acknowledge receipt and notify the party filing the appeal of all information that is required to evaluate the appeal. Molina will render a decision on the appeal within 30 calendar days from the date of receipt of the appeal. The time frame to resolve an appeal may be extended another 14 days if the Member/authorized representative or Molina think it would be in the Member's best interest (for example, additional information is needed). A letter will be sent to the Member informing them of the extension, why it was requested and that it was in the Member's best interest if the plan requests the extension. If Molina extends the time frame, the letter will also include information about the Member's right to file a grievance about extending the time frame.

Members, Member's authorized representative, or any regulatory or oversight agencies may request copies of the documents used to review the appeal free of charge. Members may ask for copies of the benefit, guidelines, or any other criteria used to make the decision. Members may also request information regarding the qualifications and specialty of the doctors who looked at the appeal. If a Molina Member would like a copy of their case file at any time, they may contact Member Services to make this request.

Expedited Appeals Process and Timeline

Expedited appeals are available when following the standard appeals time frame could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. Expedited appeals may be submitted orally or in writing. Expedited appeals can be filed within 60 calendar days from the date of notice of adverse benefit determination. If the expedited appeal is submitted orally, a written appeal request is not needed. Submit requests to:

Molina Healthcare of South Carolina
Attn: Member Appeals & Grievances
PO Box 40309
North Charleston, SC 29423-0309
Or
Via Fax: (877) 823-5961
Or
Via Phone: (855) 882-3901

Upon receipt of an expedited appeal request, Molina will notify the party filing the appeal as soon as possible, and within no more than 24 hours after receipt, of all information that is required to evaluate the appeal. If the request to expedite is approved, Molina will notify the Member of the limited time available to present evidence for the appeal and will render a decision within 72 hours of receipt of the appeal request, unless an extension is granted as mentioned above. If the request to process the appeal as expedited is denied, Molina will notify the Member or authorized representative promptly via telephone of the result of the resolution process and the date it was completed. Within two calendar days of the decision, Molina will provide written notification of the decision to deny the processing of the appeal as expedited and inform the Member that they can grieve the decision. The appeal will then be processed as a standard appeal.

Molina will attempt to provide oral notification to the Member/Member's representative of the appeal determination promptly after determination is made. Oral notification will be followed up by a written notice of determination. Where a service denial is reversed, the Provider will be notified of the determination as promptly as possible. In all appeals, Members can present evidence in person as well as in writing, and can request copies to examine the case file and other documents related to the appeal. Molina will provide these items to the Member.

A Member can ask Molina to extend the time frame to resolve an appeal by up to 14 calendar days. Molina can also extend the time frame to resolve an appeal by up to 14 calendar days if Molina thinks that the delay is in the Member's best interest. If Molina extends the time frame, we must be able to explain to SCDHHS how the delay is in the Member's best interest. We will call the Member and a letter will be sent to the Member informing him or her of the extension and why the delay is in their best interest. If Molina extends the time frame, the letter will also include information about the Member's right to file a grievance about extending the time frame.

State Fair Hearing

The State Fair Hearing system is available to Members after they have exhausted Molina's internal appeal process and are dissatisfied with the determination. Requests for a State Fair Hearing must be made no later than 120 calendar days from the date on the notice of Appeal.

Molina will participate in the State Fair Hearing process by completing all required documents within the required time frame and providing to appeal information, including, but not limited to, medical records and Claim payment records.

Continuation of Benefits

A Member has the right to continue receiving services during the appeal process if requested in writing within ten calendar days from the date on the denial notice. If the final resolution of the appeal decision is made and it is not in the Member's favor, they may be responsible for the cost of the care received during the appeal process.

Provider Claim Dispute/Claim Re-determination Request

Providers seeking a redetermination of a Claim previously adjudicated must request such action within 90 calendar days of Molina's original remittance advice date. Additionally, the item(s) being resubmitted should be clearly marked as a redetermination and must include the following documentation:

- The item(s) being resubmitted should be clearly marked as a Claim Dispute/ Adjustment
- Payment adjustment requests must be fully explained
- The previous Claim and remittance advice, any other documentation to support the adjustment and a copy of the Referral/Authorization form (if applicable) must accompany the adjustment request
- The Claim number clearly marked on all supporting documents

These requests shall be classified as a Claims Disputes/Adjustment and be sent to the following:

Molina Healthcare of South Carolina
Attention: Claims Disputes / Adjustments
PO Box 40309
North Charleston, SC 29423-0309
Or
Via Fax: (877) 901-8182

The Provider will be notified of Molina's decision in writing within 30 business days of receipt of the Claims Dispute/ Adjustment request. Providers may request a Claim dispute/adjustment when the Claim was incorrectly denied as a duplicate or due to Claims examiner or data-entry error.

Please note that Molina does not offer second level appeals.

Appendix

Molina Forms and Materials

Molina forms and reference materials are posted on the Molina website at <https://www.MolinaHealthcare.com/Providers/sc/medicaid/forms/fuf.aspx>

Forms can be found under the forms/frequently used forms tab. Examples of documents that can be found online include the following:

- Pregnancy Notification Report
- Disease Management/Care Management Referral Form
- SBIRT Integrated Screening Tool
- Abortion Statement
- Surgical Justification Review for Hysterectomy
- Neonatal Transfer Form
- Health Education Referral Form

To access additional forms, including the latest copy of the Consent for Sterilization Form, please visit the SCDHHS Provider Manual Forms section: <https://www.scdhhs.gov/internet/pdf/manuals/Physicians/Forms.pdf>

Transportation Broker Listing and Contact Information

Transportation is available for doctor appointments, dialysis, x-rays, lab work, drug store or other non-emergency medical appointments for Molina Members.

If a Member needs a ride, they can call the Healthy Connections transportation broker between 8 a.m. and 5 p.m., local time. A ride must be requested at least three days before their appointment. If a Member needs to cancel a ride, they must call at least 24 hours in advance. Members may schedule or cancel a ride by calling one of the following toll-free numbers. They can also call Member Services for assistance.

Toll-Free Phone Numbers:

(866) 910-7688

(866) 445-6860

(866) 445-9954

For more information on ModivCare, visit <http://Memberinfo.logisticare.com/scMember>

