Children's Medical Services (CMS) Plan by Molina Provider Orientation and Behavioral Health (BH) and BNet Services

August 2026

Children's Medical Services Plan BY MOLINA HEALTHCARE

MOLINA® HEALTHCARE

Agenda

1. Overview
2. CMS Plan Transition
3. What is NOT Changing
4. What IS Changing
5. Provider Relations
6. Member Eligibility
7. Contracting/Credentialing
8. Billing & Claims Submission

Agenda Continued

9 Appeals & Grievances

10 Health Care Services (HCS)/ Utilization Management (UM)

11 Care Management

12 CMS Plan Vendors & Telehealth Services

13 Behavioral Health & BNet Services

14 Covered Codes & Services

15 Required Trainings

16 Provider Resources

Session Guidelines and Provider Expectations

- **How the CMS Plan trainings are organized –** Sessions are organized by topic and provider type
  - The General Orientation sessions are for providers without a dedicated session and cover topics that apply across the network
- **Attend the session built for you –** Specialty sessions cover the general orientation and requirements specific to your services. You only need to attend one session not both the general orientation and a specialty session.
- **Sessions are muted for participants –** Participants are muted during all training sessions to allow for content to be shared as efficiently as possible
- **Questions –** Submit questions in the Q&A at any time
  - As time allows questions will be answered at the end of the session
  - FAQs will be published after the session
- **Contracting timing –** Provider interest has been substantial. Applications are being reviewed in the order received, and we ask for your patience as we work through the volume
- **How you can help –** Submit complete, accurate contracting and credentialing packets, respond promptly to requests for information, and use the published channels rather than duplicate outreach
- **Our expectations –**
  - Continuity of care for members is required. Irrespective of contracting status on 10/1. Providers should not cancel previously approved services.
  - Molina contracts with fully credentialed, verified providers and holds every network provider to high compliance and quality standards

Overview

Effective **October 1, 2026**, Molina Healthcare of Florida will solely operate Children's Medical Services (CMS) Health Plan statewide, including Behavioral Health (BH) and Behavioral Health Network (BNet) services. BH and BNet providers play a critical role in delivering medically necessary behavioral health care to children with complex behavioral health and special health care needs.

Behavioral Health and BNet Services include screening, assessment, therapy, medication management, community-based supports, and crisis services for eligible members enrolled in the Children's Medical Services (CMS) Health Plan. BNet serves children with serious emotional disturbance who meet clinical eligibility criteria, offering targeted case management and specialized behavioral health supports.

BH and BNet providers work collaboratively with the member's Primary Care Provider (PCP), CMS Case Manager, Molina Healthcare, and the member's family to develop and implement individualized treatment plans. Providers are responsible for confirming eligibility and enrollment, obtaining required authorizations, documenting medical necessity, and coordinating physical and behavioral health care to support safe, high-quality, person-centered treatment.

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Mission Statement

- **Our Mission: To improve the health and lives of our members by delivering high-quality health care.**
- We serve Florida's most vulnerable populations, and our providers are how that mission reaches members every day.
- Why this training matters:
  - Clarifies what is changing and what is not, so care continues without interruption
  - Confirms eligibility, claims, and appeals processes so you are paid accurately and on time
  - Identifies your Provider Relations contacts and self-service tools for day-to-day support
  - Supports quality, compliance, and the member experience we are accountable for together

CMS Plan Transition

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Children's Medical Services (CMS) Plan Overview

CMS Health Plan by Molina Healthcare is a Florida Medicaid specialty product for children and youth ages 0 through 20 with chronic conditions.

Eligibility

- **Medicaid: ages 0–20**, with a qualifying condition and eligibility for Medicaid
- **CHIP: ages 1–18**, with a qualifying condition and eligibility for CHIP
- A child must meet both clinical and applicable Medicaid or CHIP eligibility requirements to enroll

Program Administration

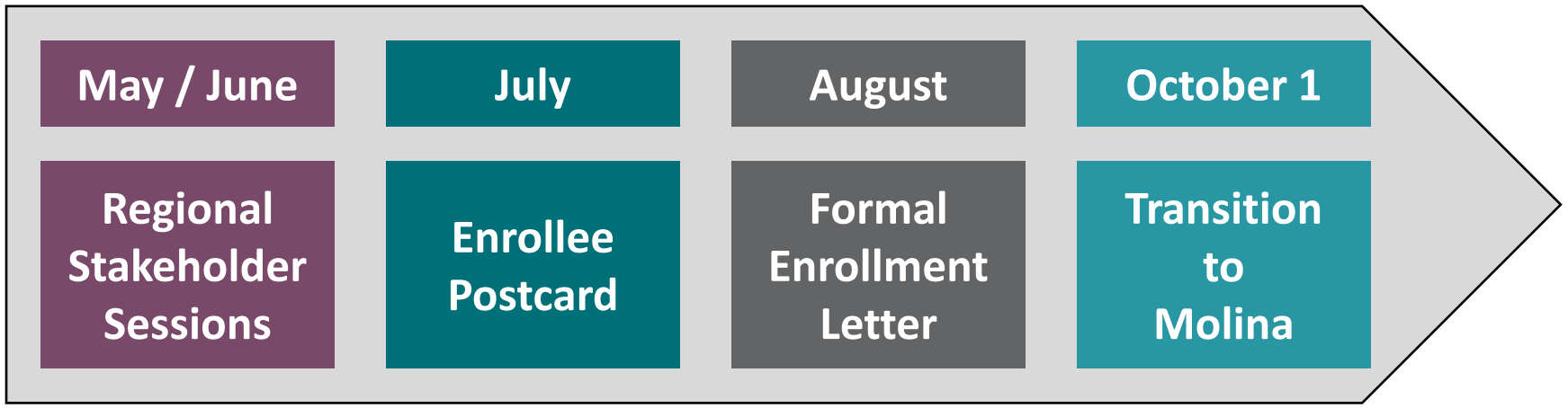
- The CMS Plan is solely administered by Molina Healthcare
- The contract applies to both Title XIX Medicaid and Title XXI CHIP recipients

Provider Takeaway

Confirm the member's CMS Plan enrollment and eligibility for the date of service. Eligibility is determined through the State's enrollment and clinical eligibility processes

CMS Plan Transition Timeline Snapshot

Effective October 1, 2026, the operation of the CMS Plan will move from Sunshine State Health Plan to Molina Healthcare of Florida



Transition Principles

- Continuity of medically necessary care
- Maintain important relationships
- Clear communication and issue resolution

About Molina Healthcare of Florida

- Molina has deep knowledge and experience having served Florida families throughout the state for more than 20 years
- Comprehensive Specialty Plan serving MMA, Long Term Care, and SMI / HIV Specialty Products
    - Offer ACA Marketplace in 20 Florida counties
- Care Management, Provider Relations, and Community Engagement staff located throughout Florida
- 4-Star Quality rating from NCQA
- Commitment to investing in Florida communities

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What Is NOT Changing

What is NOT Changing?

CMS Plan Eligibility Requirements

Child & Family-Focus

Covered Benefits & Service Categories

Member Rights & Responsibilities

What is NOT Changing?

Member Eligibility Requirements

- Must meet financial and clinical eligibility
  - Medicaid: Under 21 years old, enrolled in Medicaid, and meet clinical eligibility (as determined by Florida Department of Health (DOH))
  - CHIP: Under 19 years old, enrolled in Florida Healthy Kids, and meet clinical eligibility (as determined by DOH)

Child & Family-Focus

- Supporting strong families
- Locally-based Care Management staff
- Availability of enrollee and family services, incentives, and supports to promote health and healthy behaviors

What is NOT Changing?

Covered Medical Benefits & Service Categories

- CMS Plan enrollees will continue to get the same medically necessary covered services as they do today (e.g., acute, behavioral, therapeutic services, including pharmacy and transportation services)

Dental Services

- Dental services will continue to be provided to CMS Plan enrollees
- Dental plans will not change as a result of the CMS Plan transition:
  - CHIP enrollees: Coordinated through Molina
  - Medicaid enrollees: Provided through State Dental Health Plan

Rights & Responsibilities

- Enrollee and family rights and grievance protections

What IS Changing

What IS Changing?

Enhanced Child & Family Benefits

Improving Well-Being & Quality of Life

Child & Family Programs

Administrative & Operational Changes

Examples of CMS Plan Expanded Benefits

Additional goods and services that support the child, caregiver and household. For a full listing and details of expanded benefits review the Provider Manual (Provider Handbook)

EFFECTIVE OCTOBER 1, 2026

Health, Equipment & Safety

- Adaptive and safety devices
- Biometric equipment
- Sensory and calming aids
- Wigs, medical makeup and adaptive clothing
- Medication safety kit
- Vision aid and service-animal supports

Home & Environmental Support

- Carpet cleaning
- HEPA air filter and replacement filters
- HEPA-filter vacuum
- Hypoallergenic bedding
- Pest-control services

Meals & Transportation

- Disaster-preparedness meals
- Meals after a change in condition
- Post-discharge meals
- Medically tailored meals
- Long-distance medical-trip meal support

Self Sufficiency

- Housing assistance
- Non-medical transportation
- Food assistance

Wellness & Daily Living

- Fitness benefit
- Swimming lessons for drowning prevention
- Cellular phone service
- Collaborative care
- Respite care

OTC, Education & Caregiver

- Over-the-counter medications and supplies
- Caregiver education and support
- Tutoring and education support
- Child-welfare and social-needs supports

Molina also offers expanded benefits for transition-age youth leaving the child welfare system such as education support and more

Reminder: Benefit eligibility, limits and authorization requirements vary. Coordinate benefit-specific questions through the member's Case Manager or CMS Plan Member Services

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Child & Family Programs

- Expanded coverage of evidence-based practices
    - High-fidelity wrap around services
    - First Episode Psychosis
    - Trauma-focused Cognitive Behavioral Therapy
- Tailored programs for families of enrollees receiving the following services:
    - Nursing Facility
    - Private Duty Nursing (PDN)
    - Statewide Inpatient Psychiatric Program (SIPP)
- Adolescent and young adult-focused digital support tools

Chronic Disease Management Programs

Specialized Chronic Disease Management team addressing physical health, behavioral health, & social needs of enrollees with chronic conditions.

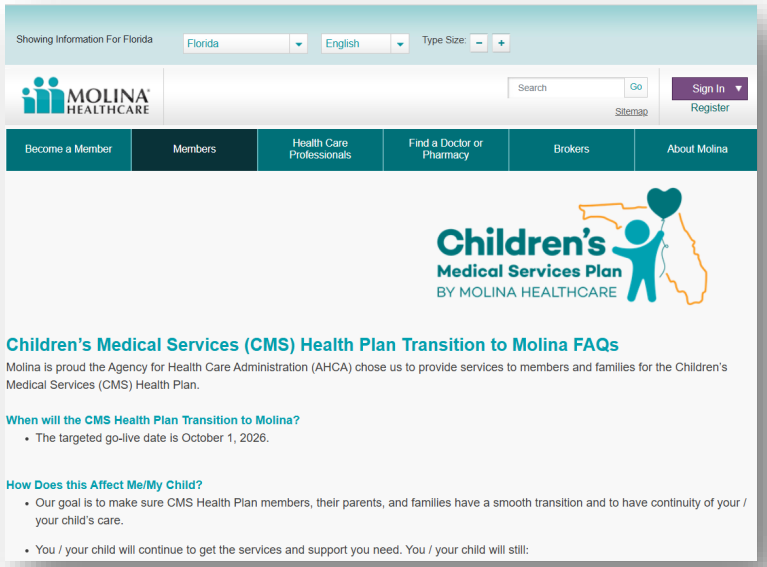
Goals

- Ensure understanding of provider treatment plan, connect to specialists
- Connect with resources & techniques to self-manage & prevent escalation
- Improve quality of life, education and social engagement, and independence
- Support young adults in establishing care with adult-serving providers

Key Chronic Conditions: Diabetes, Asthma, Cancer, Sickle Cell, Behavioral Health Conditions

Administrative & Operational Changes

- New contact information, websites, portals, and mobile apps
- Claims submission processes
- New enrollee ID cards
- Dedicated contracting and provider relations contact



Provider Relations

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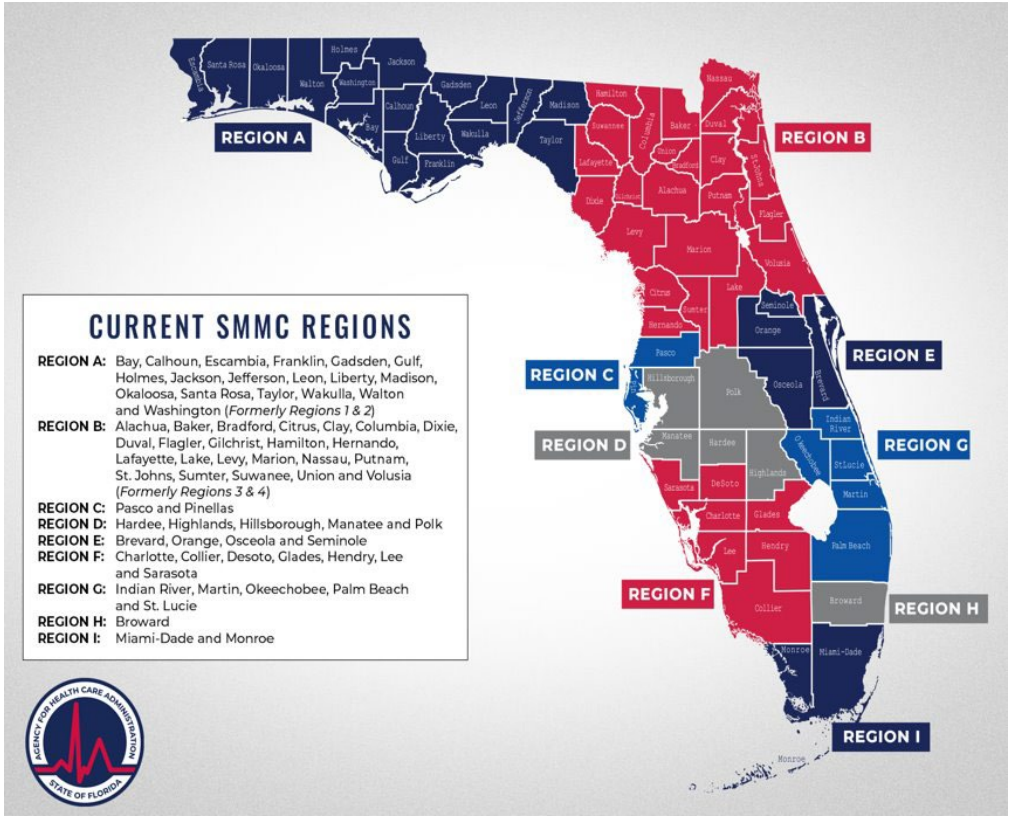
Provider Relations

Provider Relations is the liaison for providers and the health plan to support engagement, compliance, access, quality, and performance across Molina plans and stakeholders.

Regions	Meet The Team
Region A	Tiffini Whiting: Tiffini.Whiting@MolinaHealthcare.com Angie Riviere: Angie.Riviere@MolinaHealthcare.com
Region B	Trevor Rodriguez: Trevor.Rodriguez@MolinaHealthcare.com Ariel Diaz Jr.: Ariel.Diazjr@MolinaHealthcare.com
Region C	Sydney Stacy: Sydney.Stacy@MolinaHealthcare.com Vanessa Lopez: Vanessa.Lopez3@MolinaHealthcare.com
Region D	Vilma Hernandez: Vilma.Hernandez@MolinaHealthcare.com Lauren Giordano: Lauren.Giordano@MolinaHealthcare.com Edward LaMarche: Edward.LaMarche@MolinaHealthcare.com
Region E	Rossiany Castro: Rossiany.Castro@MolinaHealthcare.com Megan Gonzalez: Megan.Gonzalez@Molinahealthcare.com
Region F	Dongdow Gordon(Dee Dee): Dongdow.Gordon@MolinaHealthcare.com Shanda Lerner: Shanda.Lerner@Molinahealthcare.com
Region G	Kayla Lavieri: Kayla.Lavieri@MolinaHealthcare.com Kashala Burse: Kashala.Burse@MolinaHealthcare.com
Region H	Veronica Bermudez: Veronica.Bermudez@MolinaHealthcare.com Kashala Burse: Kashala.Burse@MolinaHealthcare.com
Region I	Mackie Hicks: Mackie.Hicks@MolinaHealthcare.com Rafael Padierne: Rafael.Padierne@MolinaHealthcare.com
Provider Relations	Phone: (855) 322-4076



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Member Eligibility

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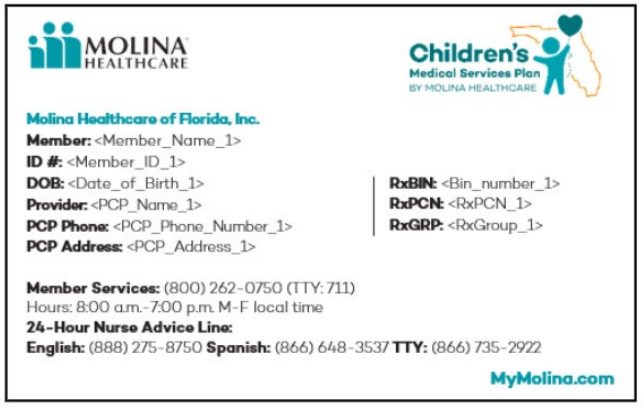
Member Services and Eligibility

Our Member Contact Center supports benefits, eligibility, pharmacy questions, PCP changes, and member complaints. Representatives are available Monday–Friday, 8AM–7PM local time, excluding state and federal holidays.

Member Contact Center		
	MMA, LTC, and HIV & SMI Specialty Plans	CMS Plan
Member Phone	(866) 472-4585 (TTY: 711)	(800) 262-0750 (TTY: 711)
Automated Voice Response	(800) 239-7560	(800) 239-7560

- Members receive a Molina Healthcare ID card in addition to their Florida Medicaid ID card and should carry both when accessing medical or pharmacy services.
- Title XIX (Medicaid) members receive dental services and associated materials from their chosen SMMC Dental Plan (not administered by Molina). Title XXI (CHIP) members receive a separate dental ID card from the CMS dental plan (administered via Molina). Dental services are verified and billed through that dental plan, not Molina.
- A Molina ID card does not guarantee eligibility or coverage. Providers must verify member eligibility before rendering services.

Verify Eligibility and Benefits (E&B) PCP Assignment through Availity
https://provider.molinahealthcare.com/
or
Call Molina FL Provider Services at (855) 322-4076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Molina Healthcare of Florida, Inc.
Member: <Member_Name_1>
ID #: <Member_ID_1>
DOB: <Date_of_Birth_1>
Provider: <PCP_Name_1>
PCP Phone: <PCP_Phone_Number_1>
PCP Address: <PCP_Address_1>

RxBIN: <Bin_number_1>
RxPCN: <RxPCN_1>
RxGRP: <RxGroup_1>

Member Services: (800) 262-0750 (TTY: 711)
Hours: 8:00 a.m.-7:00 p.m. M-F local time
24-Hour Nurse Advice Line:
English: (888) 275-8750 **Spanish:** (866) 648-3537 **TTY:** (866) 735-2922

MyMolina.com


Emergency Services: Call 911 if you can. Or you can go to the nearest emergency room (ER). Call your doctor if you are not sure you need to go to the ER. Or call our 24-Hour Molina Healthcare Nurse Advice Line at (888) 275-8750, or (866) 648-3537 (Español), or (866) 735-2922 (TTY).
Call your doctor and your Care Manager after all ER visits.

Care Management or Member Services: Call (800) 262-0750 (TTY: 711)

Claims: Billing information and Claims Submission for participating and non-participating providers: Call (855) 322-4076 or submit to: CMS Plan, PO Box 22812, Long Beach, CA 90801

EDI Claims: Payer #51062 or Call (855) 322-4076

Transportation: To schedule a trip call (844) 399-9469

Pharmacy Help Desk: Call CVS Caremark at (855) 276-6580

Children's Medical Services (CMS) Plan
1030 W 49th St., Hialeah, FL 33012

MolinaHealthcare.com

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Contracting/Credentialing

How to Join Molina Healthcare of Florida's Network

! The Molina Provider Portal is a free tool for provider enrollment and credentialing; all network credentialing requests must be submitted electronically. Before you request to join the network for CMS Program participation, the provider must be enrolled in Florida Medicaid and have a valid, active Medicaid ID issued by AHCA

1 CONNECT

Connect with Molina by submitting a contract request to join the network here **View Join Our Network webpage →** and follow the instructions for your provider type

2 DOCUMENTATION

If accepted, use the portal credentials provided to complete contracting and credentialing information and upload requested documents

3 CREDENTIALING

Meet applicable credentialing requirements, including a complete CAQH profile for practitioners or licenses and accreditations for Health Delivery Organizations (HDOs)

4 CONTRACT

Provider signs the agreement, Molina countersigns the agreement and provides a signed copy to the provider and loads credentialed providers as in-network

Key Functions

- ✓ Adding practitioners to an existing group
- ✓ Submitting credentialing requests
- ✓ Tracking credentialing and participation status
- ✓ Providing additional or missing information for enrollment or credentialing
- ✓ Uploading provider rosters
- ✓ Adding new facility locations

Provider-type routing matters

- **Vision:** contracting may involve Molina and a vision vendor
- **Pharmacy:** contact the pharmacy benefits manager
- **Dental:** contract through Molina's dental vendor
- **Home Health/Home Infusion/DME:** contact Coastal Care
- **Therapies:** contract with Molina for CMS plan and HN1 for other Molina plans
- **Existing practices:** use the portal to add practitioners or upload a roster

Need Help?

Contact Provider Services:
(855) 322-4076

Contact your Provider Relations Representative
Provider Relations Contact List

Access Behavioral Health continues as the sole delegate to manage BH services in Region A.

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Completing the Join Our Network Form

Have These Ready Before You Start

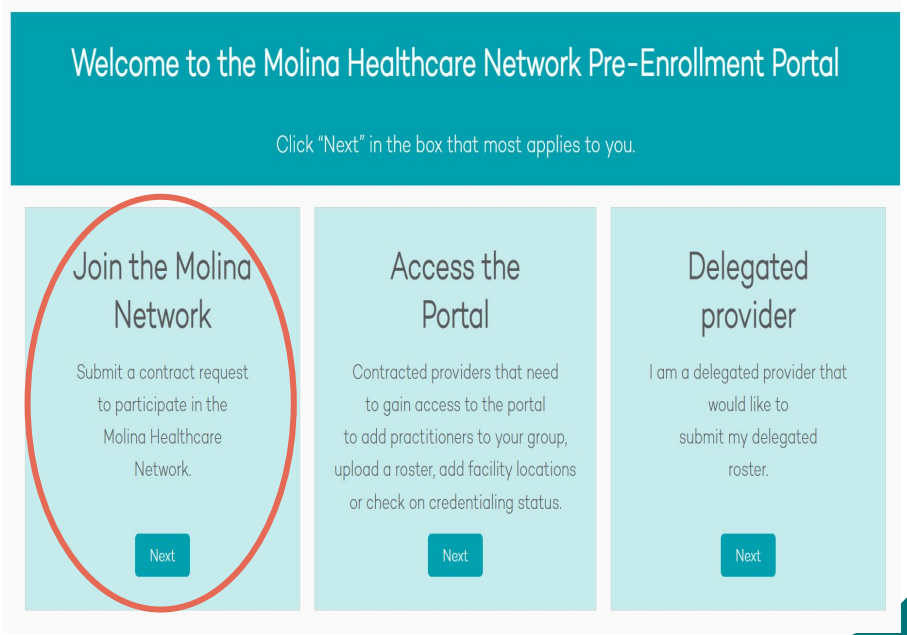
- Current W-9 matching your legal name and Tax ID
- Type 1 and Type 2 NPIs and Florida Medicaid ID
- State license, DEA where applicable, and malpractice coverage
- CAQH ID with a current attestation and Molina authorized to access it
- Accreditation, CLIA, or facility licenses for organizations
- Practitioner roster if you are adding multiple providers at once

Step-by-Step Instructions

1. Open the Join Our Network webpage and select the request form for your provider type
2. Identify the provider category: individual practitioner, group, facility or Health Delivery Organization
3. Enter organization details exactly as they appear on your W-9: legal name, Tax ID, and Medicaid ID
4. Add the Type 1 and Type 2 NPIs (where applicable), taxonomy, and specialty for the requested services
5. List every service location and the counties served, including hours and accessibility details
6. Add each practitioner to be included, with license number and CAQH ID
7. Provide a contracting contact: name, title, direct phone, and email for follow-up
8. Attach the requested documents, then review every field for accuracy before submitting
9. Submit the form and save the confirmation for your records

After You Submit

- Molina reviews the request against network need in your specialty and area
- If accepted, you receive portal credentials to complete contracting and credentialing
- Watch your email for document requests; incomplete forms delay the process
- **Right away:** save the confirmation, watch for an email acknowledging the request is in review
- **During review:** expect email updates at each stage - network decision, contract issuance, credentialing outcome
- **Once credentials are issued:** track status and document requests in the portal
- **Questions:** Provider Services (855) 322-4076 or your Provider Relations Representative



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Already Contracted? Update Your Information Online

Choose the path that matches your portal status

FIRST-TIME USER

Get your portal credentials

First time user of our new online provider portal? Please click here to receive a username and password to update your information

Click here to register →

EXISTING USER

Sign in and make updates

Existing users of our online provider portal: Please click here to access our online provider portal to update your information

Click here to sign in →

What you can update online

- **Demographics:** address, phone, tax ID, or panel status updates
- **Practitioners:** add or terminate a provider, or upload a roster file
- **Locations:** add a new service site or specialty to your agreement

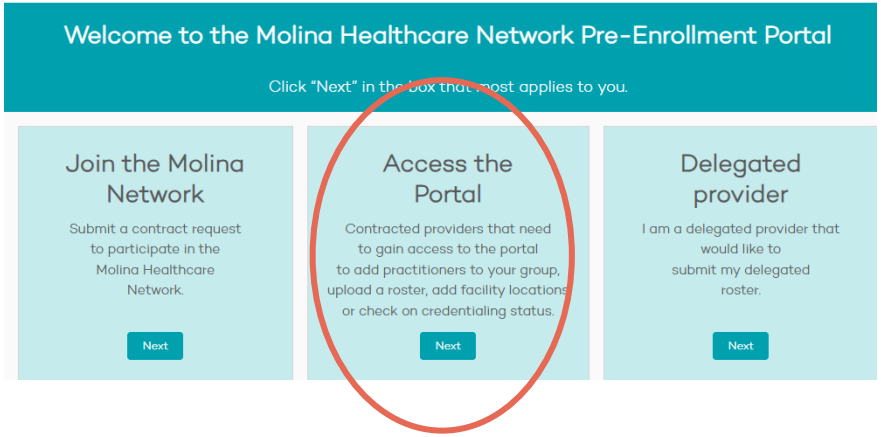
All other updates or Need Help?

- **Contact Provider Services: (855) 322-4076** or **Contact your Provider Relations Representative**
  Provider Relations Contact List

How to Update Your Provider Information

Participating Providers: Update in the Provider Portal

1. Go to the online provider portal sign-in page; first-time users select the registration link to request a username and password
2. Sign in and select the Tax ID or organization you are updating
3. Open your provider profile and choose the practitioner or location that needs to change
4. Update demographics: address, phone, fax, email, office hours, languages, and accessibility
5. Update panel status, such as opening or closing your panel to new members
6. Add or remove practitioners in the group, or upload a roster for multiple changes at once
7. Add a new service site or specialty that falls under your existing agreement
8. Attach supporting documents, including a current W-9 for any pay-to or Tax ID change
9. Submit the request and save the confirmation; updates appear in the directory after review



Submit changes as far in advance as your agreement requires so directory and claims routing stay accurate

Non-Participating Providers: Update Directly with Molina

1. Contact Provider Services at (855) 322-4076 or your Provider Relations Representative to request a data update
2. Provide a current W-9 that matches your legal name and Tax ID
3. Include your Type 1 and Type 2 NPIs (when applicable), Florida Medicaid ID, and taxonomy
4. Confirm the service location address and the remit or pay-to address
5. Give a contact name, phone, and email for follow-up questions
6. Submit the update before you file claims so payment and correspondence route correctly
7. Reference the authorization number on affected claims to avoid processing delays

Ready to contract? Use the Join Our Network request form to move to participating status and gain full portal access

How You Know It Is Moving

- **At submission:** save the confirmation number shown on screen
- **Within days:** an email confirms the request was received and is in review
- **In the portal:** the request shows as pending, then completed once applied
- **After review:** your profile and the online directory reflect the change
- **No movement?** call Provider Services with your confirmation number

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Credentialing and Recredentialing

Providers must maintain Molina credentialing and re-credentialing requirements throughout the life of the contract, consistent with state, federal, and accreditation standards. Providers are also expected to respond timely to credentialing-related information requests

Ongoing Practitioner Monitoring

- Molina is required to monitor practitioners for sanctions, exclusions, license issues, and other eligibility concerns using required federal, state, Medicaid, and specialty board sources

Follow-Up and Committee Review

- Potential matches are verified and reviewed by the Credentialing Committee, when applicable, and may result in further oversight action
- Providers and facilities approved for Molina's network are re-credentialed every 3 years

Process

- Providers receive a re-credentialing application approximately 6 months before the current credentialing period expires

Site Audit Requirement

- A site audit is required every 3 years for all rendering Primary Care, Obstetrics, and Gynecology provider service locations

Reminder: Credentialing is a requirement for services contracted through Molina vendors. Contact the vendor directly to credential and re-credential

Billing & Claims Submission

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Claim Submission

Providers may submit claims to Molina electronically using current Federal CMS 1500/UB-04 formats or approved equivalents, through the Availity Portal, or by paper submission.

Providers may register with SSI Claimsnet, LLC to submit claims using the Provider Registration Form available online at: VPS Portal Registration

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

EDI Claims Submission – All Lines of Business
Payor ID# 51062

Availity Portal
Welcome to Molina Healthcare, Inc - ePortal Services

Participating vs. Non-Participating Claim Process

Participating (In-Network) Providers

- Verify eligibility, benefits, and PCP assignment in Availity first
- No prior authorization for routine office visits
  - Confirm requirements for other services
- Submit claims via Availity, EDI Payer ID 51062, or by paper
- Claims pay at your contracted Molina rate
  - Check status and remittance in Availity
- Use the claims dispute process for reconsiderations within contract timeframes

Non-Participating (Out-of-Network) Providers

- Prior authorization is required for all services and codes, with limited exceptions such as emergency services
- Confirm your NPI, TIN, W-9, and pay-to address are on file with Molina before billing
- Submit claims via Availity, EDI Payer ID 51062, or by paper
  - Include the authorization number on the claim
- Reimbursement is 100% of the Medicaid rate unless a single-case agreement applies
- Contact Provider Services to resolve claim issues or to join the network

Paper vs. Electronic Claims Submission

Submit electronically when possible; paper Federal CMS 1500/UB-04 claims must meet Federal CMS plan print standards or claims may be rejected/returned for correction

PAPER CLAIMS: Standard

In effect since June 1, 2026

Federal CMS redline paper claim form standards enforced for Federal CMS 1500/UB-04 paper claims.

Required

- Flint OCR Red J6983 ink or exact match
- Federal CMS layout, alignment and scanability standards
- Place double Z (ZZ) indicator in front of taxonomy codes

Do not submit

- Black-and-white or photocopied Federal CMS forms
- Downloaded/printed forms that miss Federal CMS color or scale standards
- Misaligned or poor-quality prints

Non-compliant paper claims will be returned with instructions for correction.

VS

ELECTRONIC CLAIMS: Preferred Path

Why it matters

- Promotes HIPAA compliance
- Reduces paper claim costs, mailing time and delays
- Increases data accuracy and information delivery
- Errors can be corrected and resubmitted electronically

Submission options

- Availity Essentials portal at no cost to providers
- EDI clearinghouse using Payer ID 51062

Availity also supports attachments, corrected/void claims, claim status checks, status notifications, saved drafts and claim templates.

Encounter Data

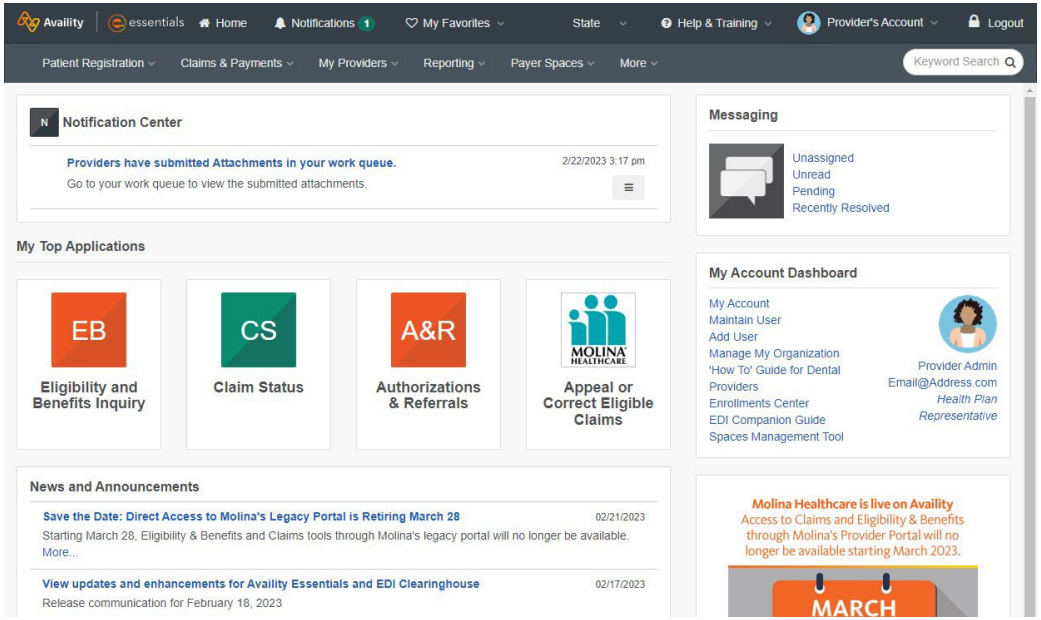
Encounter Data Submission

Providers with a Molina capitated agreement must submit encounter data for all adjudicated claims

- Encounter data must be submitted at least monthly and no later than 7 days after Molina adjudicates the claim
    - Use HIPAA-compliant transactions:
        - ANSI X12N 837I – Institutional
        - 837P – Professional; and
        - 837D – Dental
- Encounters rejected or denied due to provider errors (for example, invalid member or provider IDs, missing or invalid codes, or incomplete data elements) must be corrected and resubmitted within 15 days of the rejection or denial date
- Validate submissions before sending – verify member and provider data, NPI/taxonomy, service dates, and complete, current coding – to prevent rejections and denials
- Monitor encounter acceptance reports and address recurring error patterns to keep submissions accurate, complete, and timely

Availity Essential Portal Tools

- Verify Member Eligibility & Benefits
- Submit Authorization Requests
- Check Authorization Status
- Submit & Resubmit Claims
- Check Claim Status
- Access Remittance Viewer
- Use the Care Coordination Portal
- The Digital Correspondence Hub lets your organization manage communication preferences



What We're Asking You to Do

- Register with Availity so your organization has portal access Availity Essentials Portal
- Review the trainings on the Availity portal to learn how to use its tools
- Contact your Provider Relations Representative if you need assistance Provider Relations Contact List

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How to Register with Availity

Registration Steps (All Providers)

1. Go to availity.com and select Register
2. Choose your organization type and identify who will serve as your Availity administrator
3. Enter your organization's legal name, tax ID, and NPI exactly as they appear on your W-9
4. Verify the administrator's identity and accept the terms of use
5. Watch for the confirmation email and complete the administrator setup
6. Add users, assign roles, and add Molina Healthcare of Florida as a payer
7. Log in and complete the Availity training resources under Help & Training

Participating (In-Network) Providers

- Register using the tax ID and NPI on your Molina contract so your data matches our system
    - Atypical providers use your Tax ID to register
- Full portal access: eligibility and benefits, authorizations, claim submission and status, Remittance Viewer, and the Care Coordination Portal.
- Claim and remittance detail reflects your contracted Molina rates

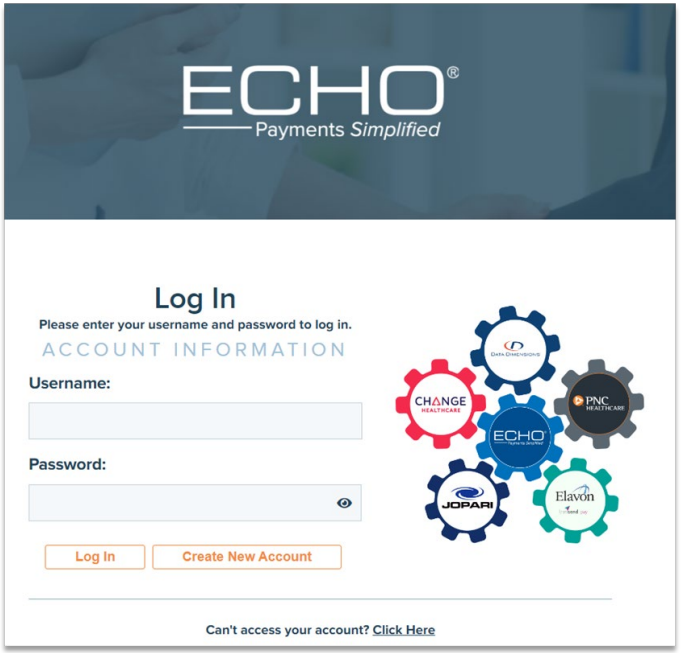
Non-Participating (Out-of-Network) Providers

- Register using your billing tax ID and NPI and confirm your W-9 and pay-to address are on file with Molina
- Use the portal to verify eligibility, submit prior authorization requests for all services, and check claim status
- Reimbursement displays at 100% of the Medicaid rate unless a single-case agreement applies
- Contact Provider Relations to request a contract and move to in-network access

Reminder: Registration with Availity can be a time-consuming process. Register now

Electronic Payment Requirements

Molina partners with **Change Healthcare/ECHO Health** for electronic payments. To avoid receiving payments on a Molina Visa Card - Providers are encouraged to **enroll immediately** with ECHO Health **after** their first Molina payment or **within 30 days** of their first payment.



Benefits of Electronic Remittance Advice (ERA)/ Electronic Funds Transfer (EFT) Enrollment:

- Faster payment turnaround via EFT
- Easy access to historical ERAs
- View, download, print & save ERAs
- Paperless Explanation of Payments (EOPs)

How to Enroll:

Visit: ECHO Health

Questions: Contact ECHO Health at **(888) 834-3511. Molina Payer ID: 51062**

Additional registration instructions are available under the **EDI/ERA/EFT** section at MolinaHealthcare.com.

Appeals & Grievances

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Provider Disputes

- A provider dispute is any disagreement related to claim processing, payment, or non-payment.
- To submit a dispute, please contact Customer Service at (855) 322-4076. You can also submit your request through **Availity**, or mail a written request with any supporting documentation to:

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

Provider disputes must be received within one (1) year of the date of payment or denial of the claim. Molina will issue a written decision within 30 days

- **Tips to avoid delays in processing:**
  - Ensure disputes/appeals include supporting documents
    - Proof of timely filing
    - Explanation of Benefits (COB claims)
    - Invoices
    - Medical Notes
    - Consent Forms

Documentation Should Include:

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

Provider Disputes vs. Appeals

Disputes	Appeals
Underpayments	Authorization denials
Overpayments	Medical necessity determinations
Timely filing	Clinical review decisions
Bundling	Supporting clinical documentation required

Additional Resources
Capitol Bridge
(800) 889-0549
FLCDR@capitolbridge.com

Reminder: Corrected claims are **not** considered disputes or appeals.

Health Care Services (HCS)/ Utilization Management (UM)

HCS Overview

Health Care Services (HCS)

Comprised of **Utilization Management (UM)** and **Care Management (CM)** working in an integrated, evidence-based model

HCS Model

Focuses on a high-touch, Member-centric approach shown to improve outcomes for Members

Provides care management for a wide range of needs, including chronic conditions requiring coordinated service

UM program includes:

- Pre-service authorization review
- Inpatient authorization management (pre-admission, admission, concurrent review)
- Medical necessity review
- Oversight of out-of-network or non-participating provider use

Utilization Management (UM)

- Ensures services are medically necessary, appropriate, and resource-efficient based on Member needs
- Promotes quality, cost-effective care across the full continuum of services
- Maintains flexibility to adjust to changes in a Member's condition
- Decisions are made by licensed clinicians and Molina Medical Directors, with peer-to-peer discussion and interdisciplinary team input available

Who Makes UM Decisions and How

Clinical Rigor Behind Every Decision

- Licensed clinicians conduct all medical necessity reviews using approved, evidence-based criteria
- Only a Molina Medical Director, unless excepted by AHCA, may issue an adverse medical necessity determination; non-clinical staff never deny for medical necessity
- Board-certified specialty reviewers and pediatric subject matter experts are used for complex and specialized cases
- Criteria are applied to the individual member, with review of the clinical record rather than codes alone
- Criteria used for a decision are available to you on request

Peer-to-Peer Review

- Treating provider or Molina Medical Director/ clinical expert may request to speak directly
- Peer-to-peer discussion available before or after a determination—often resolves questions faster than an appeal
- Request a peer-to-peer through instructions provided by UM with the adverse determination notification

Interdisciplinary Care Team and Collaboration

- Complex cases are staffed through an Interdisciplinary Care Team that includes UM, care management, behavioral health, and pharmacy
- The PCP, treating specialists, and the member and family are invited into the care plan discussion
- Clinical documentation submitted with the request keeps the review collaborative

Key Functions of the UM Program

All prior authorizations are based on a specific standardized list of services.

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

Eligibility and Oversight

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

Resource Management

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

Quality Management

- Satisfaction evaluation of the UM program using Member and Provider input
- Utilization data analysis
- Monitor for possible over- or under-utilization of clinical resources
- Quality oversight
- Monitor for adherence to Federal CMS, NCQA, State and health plan UM standards

Medical Necessity

Medicaid Reimbursement Determination

For Medicaid reimbursement, AHCA is the final authority to determine if a service is medically necessary. Determinations are based on information available at the time services were rendered and, when possible, use a physician in active practice with the same specialty/subspecialty as the physician under review.

Medicaid Rules and Medical Criteria

- Reviews apply Florida Medicaid rules and AHCA coverage policies first
- Nationally recognized, evidence-based criteria are used to support the decision where those rules do not address the specific request and are always applied to the individual member's clinical record

Provider Recommendation Alone Is Not Enough

A provider's prescription, recommendation, or approval does not, by itself, make a service medically necessary, a medical necessity, or a covered service/benefit

Inpatient Hospital Services

For inpatient hospital services, medical necessity means appropriate medical care cannot be provided more economically on an outpatient basis or in another type of inpatient facility

EPSDT for Members Under 21

Under Early and Periodic Screening, Diagnostic and Treatment, members under 21 are eligible for any medically necessary service that corrects or improves a condition identified through screening, including services beyond standard coverage limits

Special Services Process

- Services outside standard limits are requested through the special services process
- Submit the request with clinical documentation supporting medical necessity
    - A Molina Medical Director reviews it and written notice of the determination is issued

Requests should follow standard authorization processes and include all supporting medical necessity documentation

Prior Authorization (PA) Request

CMS Plan requires prior authorization for certain services to meet federal and state requirements and the terms of the Molina Hospital or Provider Services Agreement. A detailed list of services requiring authorization, including applicable CPT and HCPCS codes, is available for provider reference.

Prior authorization is not required for office visits with participating network providers. Non-participating providers require authorization for all services and submitted codes, except for emergency services, evaluation and management codes during non-elective observation or inpatient admissions, or when otherwise required by law.

Prior-Authorization Look-up Tool:
Florida Providers Home

Service Request can be submitted via the
Provider Availity Portal

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Prior Authorization Submission

Providers must submit prior authorization requests through the Availity Portal. Requests must include enough information for Molina to review medical necessity and process the request timely

Required Information

- ✓ Member demographics: name, date of birth, and Molina ID number
- ✓ Provider details: referring provider and referred-to provider/facility, including address and NPI
- ✓ Diagnosis and ICD-10 code(s)
- ✓ Requested service/procedure with applicable CPT and HCPCS codes
- ✓ Service location
- ✓ Clinical documentation supporting medical necessity, including:
  - ✓ Pertinent history, treatment, diagnostic tests, examination findings
  - ✓ Inpatient length of stay when applicable
  - ✓ Rationale for expedited processing when requested

Additional Information

For full requirements and service-specific guidance, providers should reference the **Prior Authorization/Utilization Management** section of the Molina Provider Manual or refer to the Prior Authorization Tool on our website: Florida Providers Home.

Submitting an Authorization in Availity

Step-by-Step in the Portal

- Log in to Availity Essentials and select Molina Healthcare of Florida as the payer
- Confirm eligibility and benefits, then check the Prior Authorization Look-Up Tool to verify authorization is required
- Open Patient Registration and select Authorizations & Referrals, then Authorization Request
- Choose the request type and enter member demographics and Molina ID
- Add requesting and servicing provider or facility with NPI, diagnosis and ICD-10 codes, CPT/HCPCS codes, service location, and dates of service
- Mark the request urgent or routine and attach clinical documentation supporting medical necessity
- Submit and save the confirmation number, then track status under Auth/Referral Inquiry

Non-Participating Providers

- Authorization is required for all services and codes, except emergency services
- Register for Availity and follow the same steps as above
- Submit a current W-9 and NPI for payment set-up
- Active authorizations appear in the portal under the member's Molina ID

Missing a Sunshine Health Authorization?

- Active authorizations transferred from Sunshine Health should appear in the portal under the member's Molina ID
- If you do not see an existing authorization, do not delay care. Contact Molina before rescheduling or cancelling the service
- Have the member ID, service dates, CPT codes, and the prior authorization number ready when you call

Who to Contact

- Missing or transitioned authorizations: Molina Provider Services at (855) 322-4076
- Portal access, log-in, or submission errors: Availity Client Services, or your Provider Relations Representative
- Clinical or urgent authorization questions: Molina Utilization Management through Provider Services

Questions?

Call Provider Services for help at (855) 322-4076

Urgent vs Routine Requests

Definitions

- **Urgent:** Use when delay could cause serious health deterioration, prevent the member from regaining maximum function, or result in severe unmanaged pain
- **Routine/non-urgent:** Submit all requests that do not meet urgent criteria as routine/non-urgent

Processing Timeframes

- **Urgent:** Processed within 2 calendar days
- **Routine/non-urgent:** Processed within 3 calendar days of the initial request

Provider Review Options

- Providers may request the criteria used for the final authorization decision
- Providers may request to speak with the Medical Director who approved or denied the request

In-Network Specialist Referrals

Referral Guidance

- Refer members when services are outside the PCP's scope or specialty consultation/treatment is needed, except for emergency services
- PCPs and specialists should exchange information to support continuity of care; referrals must be documented in the medical record with specialty, requested service, and diagnosis

Network Use

- Direct members to Molina-contracted and credentialed providers/facilities when applicable. Out-of-network referrals require prior authorization, except for emergency services
- Specialists are to submit prior authorization requests directly to Molina and **should not** send members back to PCPs to submit on their behalf

No Referral Required

- Members may go directly to in-network Obstetrics and Gynecology, Dermatology, Chiropractic, Behavioral Health (routine outpatient), and Podiatry.
- Referrals are also not required for well-child visits, urgent care, family planning, or emergency services

Routine outpatient behavioral health may be self-referred; BNet referrals are coordinated through Molina CMS Plan Care Management. Prior authorization still applies where required

Continuity of Care (COC)

Molina will support a smooth CMS Plan transition by honoring existing approved services and treatment plans before October 1, 2026, until the member's ongoing care plan is finalized

COC Timeframes

Current transitioning CMS Plan members: up to 240 days

New CMS Plan members from another SMMC Health Plan or Medicaid Fee-For-Service delivery system: up to 180 days

Existing Authorizations

Molina will honor approved authorizations before October 1. Enrollees continue seeing current providers up to 240 days **or** until treatment plans with Molina are finalized, whichever is sooner

Your current authorization number from Sunshine **will not** change while that authorization is active. **You may, but are not required to submit a duplicate request**

Provider Action

Continue appointments and medically necessary services rendered in good faith and that have an existing approved authorization

Keep documentation supporting ongoing care

What Providers Should Do During COC

- Do **not** cancel appointments for CMS Plan members due to the transition
- Use the existing authorization number from the prior plan for billing when an authorization is already on file
- Submit requests for continued services **before** the current authorization or treatment period ends
- Submit a **new request** when services change, additional units are needed, or no authorization is on file
- **Submit the treatment plan with your claim** when no transition authorization is on file. Molina reserves the right to review all treatment plans
- During the COC period:
  - Contracted providers will be reimbursed at your Molina rate.
  - Non-Participating providers will be reimbursed at the rate they received immediately prior to transition (with proof). Default reimbursement is 100% Medicaid

When to Contact Molina UM

Contact Utilization Management for continued care requests, new or changed services, or questions about COC authorizations

Phone: (855) 322-4076

Reminder: COC supports continuity during transition. Requests for changed, additional, or ongoing services beyond the current authorization will require Molina review

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COC Provider Scenarios: Authorizations & Payment

Existing CMS Member: COC up to 240 days

Current authorization is on file

Authorization
- Continue medically necessary services
- Use the existing authorization number from the prior plan
- **You may submit an authorization request, but you do not need to submit a duplicate request**

Payment
- Claims should align to the authorization on file

Modification to existing approved authorizations or additional services beyond approved authorization

Authorization
- Submit a new or updated authorization request through Availity
- Include clinical documentation and the reason for the change

Payment
- Claims should match the newly approved service, units and span
- Services beyond the current authorization may require Molina review

New CMS Member: COC up to 180 days

New member has prior Medicaid services

Authorization
- Submit prior authorization or COC documentation showing the member was already receiving the service
- Include treatment plan, medical records, or prior authorization correspondence
- COC covers the same service already in place; a new or different service is not COC and needs a standard authorization
- For services beyond the prior authorization or treatment plan, submit a re-certification request through Availity

Payment
- With supporting COC documentation, claims can be processed during the COC period
- If documentation is missing, Molina may request more information

No documentation or COC does not apply

Authorization
- Submit a standard authorization request before rendering a service that requires authorization
- Attach medical necessity documentation
- Use the PA look-up tool if unsure whether authorization is required

Applies in Every Scenario — the up to 240-day and up to 180-day windows set only the COC entry period

- **Non-participating providers:** default reimbursement is 100% Medicaid rate unless proof of another prior reimbursement rate is received
- **Documentation drives payment:** claims without required authorization or supporting documentation may deny
- **Never bill the member** for covered services

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Care Management

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Care Management Services

PCP/Provider Responsibilities in Care Management

- Coordinate care with the Care Manager
- Share changes in the member's health status and treatment plan
- Support the member's Individualized Care Plan (ICP)

Care Manager Responsibilities

- Coordinate care across providers and services
- Develop and monitor the Individualized Care Plan (ICP)
- Connect members with appropriate resources and support such as:
  - Evidence based programs
  - Transitions of care (inpatient to outpatient)
  - Statewide Inpatient Psychiatric Program (SIPP)
- Coordination of Interdisciplinary Care Team meetings

Care Management Provider Contact Information	
Provider Phone	(855) 322-4076
Provider Email	MemberSupportCMSFL@molinahealthcare.com

Pediatric Disease Management Programs

Asthma	Behavioral Health	Behavioral Health: Substance Use
Cancer	Diabetes	Digestive Disorders (IBD & Celiac Disease)
Heart Conditions	Hemophilia	HIV
Kidney Disease	Obesity	Sickle Cell Disease
	Advanced Therapies (Transplant & Gene Therapy)	

Providers may refer members by contacting the members Care Manager

Quality Program: A Shared Responsibility

Quality for CMS Plan members depends on what we do together, so here is what the program measures and what each of us are responsible for

The CMS Plan Quality Program

- A Quality Improvement Program built to regulatory and accreditation standards, with defined governance, scope, goals, and measurable objectives
- HEDIS is our clinical measurement standard, and results are reported to regulatory and accrediting agencies
- Quality is broader than HEDIS: we also measure member outcomes and track program goals beyond those metrics
- CAHPS surveys members each spring on getting needed care, getting care quickly, how well doctors communicate, and coordination of care
- Well-child and adolescent EPSDT measures set the state standard for children's preventive care
- Peer review, site visits, and medical record-keeping reviews support the program

What We Ask of You

- Engage in the Quality Program overall, including peer review and audits of care
- Share information with us proactively rather than waiting for a request
- Take part in program and process improvement work: PCMH, Behavioral Health Home, complex care management, value-based payment, Pay for Quality, and the Quality committee
- Help drive evidence-based practice in day-to-day care
- Meet access to care and appointment availability standards
- Complete well-child and EPSDT exams and file the AHCA Well Child Visit Tracking Form in the record
- Enroll in Vaccines for Children and keep an adequate vaccine supply
- Provide medical records for quality review, HEDIS, and appeals, and retain member records at least 10 years
- Support site and record-keeping reviews and cooperate with grievance investigations
- Close the care gaps you see when checking eligibility

What You Can Expect From Molina

- HEDIS care gaps visible in the portal when you verify eligibility and benefits
- A written copy of the Quality Improvement Program on request from Provider Services
- Clinical guidelines, quality reporting, and performance feedback
- Care Management partnership for members with complex or ongoing needs
- Decisions based only on appropriateness of care and coverage, with no incentives for denials or under-utilization
- Provider Relations education and support; Health Education line at (855) 322-4076

Questions about quality measures or reports? Contact Provider Services at (855) 322-4076 or your Provider Relations Representative.

CMS Plan Vendors and Telehealth Services

Telehealth Services

CMS Plan members may receive appropriate physical and behavioral health services through participating providers using telehealth or telemedicine.

Common Uses

- Lab or imaging results
- Therapy and counseling
- Recurring-condition follow-up
- Skin conditions
- Prescription management
- Urgent care concerns
- Post-surgical follow-up

Provider Requirements

- Use technology with applicable safeguards
- Comply with HIPAA and state and federal privacy law
- Follow CMS Plan telemedicine policies and procedures
- Complete required training and attestation before offering virtual care

Provider Takeaway

- Confirm the service is clinically appropriate and covered
- Verify member eligibility
- Check prior authorization requirements
- Document the encounter as you would an in-person service
- Not all participating providers offer telehealth

Reminder: Telehealth is generally delivered online using a computer, tablet, or smartphone

Pharmacy and Laboratory Partners

Use the partner assigned to the service and confirm CMS Plan coverage and authorization requirements before directing care

CVS Caremark | Pharmacy Benefit Manager

Supports the pharmacy network, formulary, and pharmacy claims

Provider actions:

- Verify the current formulary and prior authorization requirements
- Submit complete clinical information when authorization is required
- Contact CVS Caremark at (800) 237-2767 for pharmacy network or claims questions

Pediatric pharmacists on the CMS Plan team review complex pediatric regimens and advise on dosing, safety, and interactions

- Ask for pediatric pharmacist support through the members Care Manager

Quest Diagnostics and LabCorp | Laboratory Services

Direct outpatient laboratory work to participating laboratory providers unless an approved in-office test applies

Quest Diagnostics: (866) 697-8378
LabCorp: (800) 845-6167

Provider action: Use the Molina provider directory and CMS Plan guidance to confirm network participation and service requirements

Reminder: Verify member eligibility and use the Prior Authorization Look-Up Tool when applicable

Transportation and Vision Partners

Use the CMS Plan-specific routing shown below. Product routing from other Molina plans may be different

MTM Health | Non-Emergency and Non-Medical Transportation	Supports non-emergency transportation for covered services Scheduling line: (888) 298-4781 When coordinating a ride, have the member information, appointment date and time, provider location, and accessibility needs available Emergency transportation is not scheduled through this line
Vision Services | Confirm CMS Plan Network	Confirm the member's benefits and network before scheduling or billing Unsure on the vision network that applies call: Provider Services: (855) 322-4076

Home-Based Services: Coastal Care and HHAeXchange

The two partners support different parts of the CMS Plan home-based services workflow

Coastal Care Services | Network and Service Administration

Supports DME, home health, and home infusion

PDN services for the CMS plan are contracted through Molina Healthcare and **NOT** with Coastal Care

Practitioners: Order services and follow applicable authorization requirements.

DME, home health, and home infusion provider types contract and credential through Coastal Care rather than Molina.

Contact: (855) 481-0505

HHAeXchange | Electronic Visit Verification

Supports authorizations, scheduling, visit verification, and billing for applicable home-based services including home health, personal care, and private duty nursing

New agencies should self-register and complete required training.

Visits must be electronically verified for services subject to EVV. Providers should use the approved workflow for confirmed visits and billing.

Dental Services and Independent Review

These partners have distinct roles and should be used only for the function they manage

State Dental Health Plan | Dental Services

Medicaid dental services continue through the State Dental Health Plan.

CHIP dental is coordinated through Molina, consistent with CMS Plan guidance.

Providers should use the member's dental identification and verify dental eligibility and billing instructions with the applicable dental plan.

Capitol Bridge | Independent Review

Used when a provider requests independent review of an eligible appeal decision

Phone: (800) 889-0549
Email: FLCDR@capitolbridge.com

A corrected claim is not an appeal or dispute. Follow the standard corrected-claim process when claim data needs correction

Reminder: For routing questions, start with Provider Services at (855) 322-4076 or your Provider Relations Representative

Language Access and Therapy Services

Two supports every CMS Plan provider should know how to use and how each is arranged with Molina

Interpreter and Translation Services

No cost to provider or member, 24/7

- Oral interpretation in any language by phone, on-site interpreters when needed, and American Sign Language
- Written member materials in Spanish, Haitian Creole, large print, braille, audio, and other alternate formats on request
- Do not rely on family members to interpret
- Request through the Provider Contact Center at (855) 322-4076; members may call CMS Plan Member Services at (800) 262-0750 (TTY: 711)
- Post the Nondiscrimination Notice and Tagline Document, offer auxiliary aids, and complete CLAS training in the Availity Learning Center within 30 days of onboarding

Therapy Services PT, OT and Speech

Arranged directly with Molina

- For the CMS Plan, therapy is managed directly by Molina Healthcare — HN1 / American Therapy Administrators does NOT apply to CMS Plan members
- Contract and credential with Molina, then submit prior authorization through Availity Essentials with supporting clinical documentation
- Check the Prior Authorization Code Look-Up Tool first, or call Healthcare Services at (855) 322-4076
- PT and OT, ages 0–20: one initial evaluation per year, up to 210 minutes of treatment per week, one initial wheelchair evaluation every five years
- Speech therapy, ages 0–20: one initial evaluation per year, up to 210 minutes per week, plus communication devices and services
- Coordinate with the member's Case Manager so therapy goals stay aligned with the plan of care

Reminder: For routing questions, start with Provider Services at (855) 322-4076 or your Provider Relations Representative

Administrative and Payment Partners

These partners support the provider workflow but do not replace CMS Plan eligibility, authorization, or billing requirements

Availity Essentials

- Eligibility and benefits
- Prior authorization submission and status
- Claims and corrected claims
- Claim status and remittance
- Care Coordination Portal

Register through Availity and add Molina Healthcare of Florida as a payer

SSI Claimsnet, LLC

- Electronic claims clearinghouse option
- Providers may register online to submit EDI claims
- Use Molina Payer ID 51062
- Claims must include complete provider, member, coding, and authorization information when applicable

Change Healthcare / ECHO Health

- Electronic funds transfer and electronic remittance advice
- Enroll with ECHO Health promptly and no later than 30 days after the first Molina payment to avoid virtual-card payment
- Questions: (888) 834-3511
- Payer ID: 51062

Behavioral Health and BNet Services

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Member Eligibility Reminder

Member Eligibility Criteria

- Are enrolled in the Children's Medical Services (CMS) Plan and Medicaid eligible
- Are under 21 years of age
- Have a covered behavioral health diagnosis and meet medical necessity criteria
- May self-refer for routine outpatient behavioral health; authorization required for higher levels of care

Before the First Visit

- Verify CMS Plan eligibility and behavioral health benefit through Availity on the date of service
- Verify prior authorization for services that require it
- Identify the assigned CMS Plan Case Manager and confirm consent and release forms

Covered Codes & Services

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Coverage Guideline and Codes Links

Main Behavioral Health Coverage Policy

- **Medical and Behavioral Health Coverage Policy** – Overview of AHCA's policy units, including Behavioral Health, and coverage criteria for behavioral health services
  Medical and Behavioral Health Coverage Policy Florida Agency for Health Care Administration

Behavioral Health Community Support Services

- **Rule 59G-4.031** – Governs Medicaid coverage for behavioral health community support services
  59G-4.031 Behavioral Community Support Services Guide.pdf

Behavioral Health Assessment Services

- **Rule 59G-4.028** – Governs Medicaid coverage for behavioral health assessment services
  59G-4.028 Behavioral Health Assessment Services Guide

Behavioral Health Interventions:

- **Rule 59G-4.370** – Governs Medicaid coverage for behavioral intervention services
  59G-4.370 Behavior Intervention Services Guide.pdf

Behavioral Health Medication Management:

- **Rule 59G-4.029** – Governs Medicaid coverage for behavioral medical management
  59G-4.029 Medication Management Services Guide.pdf

Coverage Guideline and Codes Links Continued

Behavioral Health Overlay: BHOS Proposed Rule

Child Targeted Case Management:

- **Rule 59G-8.700** – Governs Medicaid coverage for CHS targeted case management services
  59G-8.700 CHS Targeted Case Management Coverage and Limitations Handbook_June 2012 (2).pdf

MH Targeted Case Management: CL_07_070601_MH_Case_Mgmt_ver2_2.pdf

SIPP: SIPP_Coverage_Policy_Proposed

Therapeutic group care:

- **Rule 59G-4.295** – Governs Medicaid coverage for therapeutic group care services
  59G-4.295_Therapeutic_Group_Care_Services.pdf

Medicaid Policy Hub

- **Medicaid Policy** – Links to all coverage policies, including behavioral health
  Medicaid Policy | Florida Agency for Health Care Administration

Medicaid Fee Schedule

2026 CBH Fee Schedule.pdf

Behavioral Health-Related Expanded Benefits & Programs

Additional supports beyond standard Medicaid-covered behavioral health services

1 Direct BH-related supports

- Sensory and calming aids
- Collaborative care
- Respite care
- Adolescent and young adult digital support tools

2 Child & family programs

- High-Fidelity Wraparound
- First Episode Psychosis
- Trauma-Focused Cognitive Behavioral Therapy
- Expanded evidence-based practices

3 Whole-family supports

- Family caregiver support
- Education and support services
- Cellular phone service
- Supports addressing health-related social needs

REMINDER: Standard covered services continue. These added benefits and programs may support the member's care plan, family stability and access to services. Coverage requirements, limits and authorization may apply

In Lieu of Services

In-lieu-of services are medically appropriate, cost-effective substitutes for a covered service. They are useful when the covered benefit is not the right setting or the member declines/does not qualify for it

Covered Benefit	Proposed In Lieu Of	Prior Authorization Required
Emergency behavioral health care	Mobile crisis assessment & intervention (community)	No
Psychosocial Rehabilitation Services	Self-Help / Peer Services	No
Clubhouse services	Drop-in Center	No
Psychological Testing Services	Infant Mental Health Pre & Post Testing	No
Office-based therapy and/or TBOS	Family Training and Counseling	No
Inpatient Hospital Services / residential / SIPP	Multisystemic Therapy (MST)	No
Outpatient / ED / inpatient hospitalization	Functional Family Therapy (home or community)	Yes
Inpatient Hospital Services	Behavioral Health Intensive Outpatient (IOP)	Yes
Inpatient psychiatric hospital care	Mental Health Partial Hospitalization (PHP)	Yes
Therapeutic Group Care / Statewide Inpatient Psych Program	Community-Based Wrap-Around Services	Yes
Inpatient detoxification hospital care	Substance Abuse IOP	Yes
Inpatient detoxification hospital care	Substance Abuse Short-Term Residential (SRT)	Yes
Inpatient detoxification hospital care	Ambulatory detoxification services	Yes
Emergency BH / inpatient (SMI/SUD)	Housing Assistance & Targeted Case Management	Yes

Overview of Evidence Based Programs

- Evidence Based Programs (EBPs) are programs that have been proven effective through outcome evaluations
- EBPs are based on research and validated results
  - Validation is for a specific problem with a targeted population
  - Scientific research and empirical evidence will guide clinical interventions
- EBPs are likely to be effective in changing target behaviors
  - Programs must be implemented as designed
  - Programs must be administered with fidelity and integrity to their respective model
  - Any changes may invalidate the effectiveness of the program

Molina supports the use and expansion of Evidence Based Programs. If you offer or would like to offer these programs, please contact Molina for a contract amendment through your Provider Relations Representative

Evidence Based Programs for Children with Intensive Behaviors

- Molina of Florida members have access to behavioral health programs
- There are 14 EBPs focused primarily on child and adolescent members with intense behaviors as part of the Child Welfare Program
- How will these services support our members?
  - Reduce BH and Baker Act admissions
  - Strengthen family relationships
  - Build resiliency in children and parents
  - Prevent child abuse and neglect
  - Improve overall health outcomes

Evidence Based Programs

Program Name	Target Population	Key Elements	Target Outcomes
Brief Strategic Family Therapy	Families with children under age 18 displaying high risk behaviors	• Brief interventions to address adolescent substance abuse, conduct problems, oppositional, aggressive or violent behaviors • Services provided directly to parents/caregivers and addresses lack of parental leadership, unhealthy parental collaboration and lack of nurturance to adolescents in their care • Services generally last average of 12-16 weekly sessions	• Decrease the likelihood of juvenile justice involvement • Strengthen parenting skills, keep families intact and increase family bonding

Community Action Team	Families with children age 0-17	• Multidisciplinary team and in-home/on-site approach
		• Services include comprehensive assessment, individualized care planning and case management, crisis intervention, therapy, skill building, and linkage to community resources
		• Respond to emerging needs and provides flexible support in settings that are most comfortable and accessible for the youth and family.
			• Empower youth and families, enhance resilience, and support safe, stable participation in their homes, schools, and communities.
			• Improving functioning in key life domains such as:
			  ○ School attendance and performance
			  ○ Family relationships
			  ○ Emotional regulation and coping skills
			  ○ Social functioning and community participation

First Episode Psychosis	Adolescents and young adults between the ages of 15 and 18 who are experiencing the first episode of psychosis or early psychotic symptoms	• Psychoeducation on the appropriate use of antipsychotic medications and monitoring effectiveness and side effects. • Case management and coordination of behavioral health, medical, educational, and social services ensure continuity of care and reduce barriers to treatment. • Engagement with trained peer specialists provides encouragement, shared experience, and support for recovery goals, including strategies to recognize early warning signs, prevent relapse, and respond effectively to symptom exacerbation.	• Reduce the duration of untreated psychosis, minimize the long-term impact of psychotic disorders, and support individuals in achieving recovery and maintaining participation in school, work, and community life. • Reduce the risk of chronic disability associated with untreated psychotic disorders. • Strengthen family understanding and involvement in treatment to reduce stigma and improve engagement with behavioral health treatment, promoting long-term recovery and community integration.

Evidence Based Programs

Program Name	Target Population	Key Elements	Target Outcomes
Functional Family Therapy	Families with children ages 11-18	• Family Intervention program for at-risk youth exhibiting behavioral or emotional challenges and their families • Programming delivered by master's level therapists, meeting weekly for 60 – 90 minutes with families in the home setting over the course of 3-6 months • Phasic program with steps which build upon each other (Engagement, Motivation, Relational Assessment, Behavior Change, Generalization)	• Improve coping skills • Improve family cohesion
Healthy Families	Parents of children under 5 years of age or expecting a new child	• Multi-year, intensive, home visits for families with history of trauma, intimate partner violence, mental health and/or substance abuse issues • Services promote healthy parent-child interaction and attachment, increasing knowledge of child development and improving access to use of services and reducing social isolation • Enrollment begins prenatally and generally consists of weekly home visits by specially trained staff. Families may remain in program an average of 3 years	• Prevention of child abuse and neglect • Strengthening of parent/child bond and improvement of parenting skills • Promote child health and wellness and improve prenatal care
High-Fidelity Wraparound	Families with children age 0-17 years	• Frequent assessment and treatment plan progress reviews. • Administered in a team-based approach which may include family members, healthcare providers, social service agencies, and other community-based organizations. • Team meetings work in tandem with the youth and their family to prioritize their needs and support interventions to maintain the youth at home and in the community. • Family or caregiver involvement is a mandatory component of the HFW program and is pivotal to successfully maintaining the member in the community setting.	• Prevent the need for Therapeutic Group Care (TGC) and Statewide Inpatient Psychiatric Care (SIPP) • Build the family's long-term ability to manage challenges

Evidence Based Programs

Program Name	Target Population	Key Elements	Target Outcomes
Homebuilders	Families with children ages 17 or younger	• Home and community based intensive family preservation services • Goal is to avoid unnecessary placement into foster care, group care, psychiatric hospitalizations or juvenile justice facilities • Program model engages families by delivering services in natural environment • Parents/caregivers participate as partners in assessment, goal setting and treatment planning • Delivered primarily in family home over 4-6 weeks averaging 40 direct hours • Families have access to clinician 24/7	• Stabilize living situation and keep child at home or natural environment • Improve parenting skills and family unit cohesion
Motivational Interviewing	Individuals within all age groups	• Person-centered, directive method designed to enhance internal motivation for behavior change • Helps reduce unwanted behaviors by empowering the individual receiving treatment to be driver of their own change • Can be used as standalone treatment or in conjunction with other treatment	• Enhance parents/caregivers desire to change unwanted behaviors preventing them from supporting child's health or wellbeing
Multisystemic Therapy	Families with children ages 12-17	• Intensive treatment for high-risk youth • Family and community-based treatment addressing all environments to promote pro-social behaviors and reduce criminal activity • Therapy provided in all setting where youth exists and lasts average 3-5 months • Therapist available to family 24/7	• Improvement of disruptive behaviors • Improve parental/caregiver mental health and coping skills

Evidence Based Programs

Program Name	Target Population	Key Elements	Target Outcomes
Nurse Family Partnerships	First time mothers who are pregnant or have a child under 2 years of age	• Home visits completed by registered nurses to first-time, low-income mothers • Focus is on women's health, pregnancy outcomes, early childhood development and parenting capacity • Nurses provide support related to individualized goals, parenting skills, educational and career planning and preventative health • Nurses provide weekly visits, averaging 60-75 minutes to first-time mothers until child is 2 years of age	• Improve pregnancy outcomes by helping participants engage in preventative health practices • Improve child health and development • Improve economic self-sufficiency of the family by supporting parents with education and career planning resources
Parents as Teachers	Expectant parents and parents with children up to age 5	• Early childhood parent education program • Focus is on family well-being, school readiness and home visiting model • 4 core components: personal home visits, supportive group events, child health and developmental screenings, community resource networks) • 1-2 Monthly home visits by certified parent educators averaging minimum of 60 minutes over course of 2 years.	• Increase parent knowledge of early childhood development and improve parenting practices • Provide early detection of developmental delays • Prevent child abuse and neglect • Increase child's school readiness and success

Trauma Informed Care Programs

Program Name	Target Population	Key Elements	Target Outcomes
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Children between ages 3-18 and their parent/caregivers	• Psychosocial treatment model designed to treat post-traumatic stress and related emotional and behavioral problems in children • Initially developed to address trauma related to child sexual abuse but has been adapted to support children who have experienced foster care placement • Therapeutic interventions may include relaxation techniques, cognitive coping skills, psycho-education and parenting skills • Duration of treatment is generally 12-18 weeks of weekly 30–45-minute sessions individually and jointly with parent/caregiver and child	• Improvement child PTSD, depressive and anxiety symptoms • Improvement of parenting skills and parental support of child • Reduction of parental distress • Improvement of child's adaptive functioning and reduction of shame related to traumatic experiences
Child Parent Psychotherapy (CPP)	Children between ages 0-5 and their parent/caregivers	• Relational treatment model for trauma-exposed children ages 0-5 • CPP integrates skills from developmental, social learning, psychodynamic and cognitive behavior therapies • Interventions with therapist may include trauma exposure therapy, • Services are usually administered to child AND parent/caregiver in weekly sessions averaging 1-1.5 hours • Average program duration 52 weeks (1 year)	• Strengthen relationship between child and caregiver • Improve child's perception of safety and caregiver attachment • Decrease behavioral problems and mental health symptoms
Parent- Child Interaction Therapy* * Evidence Based Program	Families with children ages 2-7	• Focus on decreasing child's externalizing behaviors (defiance, truancy, extreme mood swings, ineffective social skills, etc.) • Teaches parent/caregiver traditional play therapy skills, positive reinforcement and traditional behavior management skills • Average of 12-20 sessions administered by certified PCIT therapist	• Improve parenting skills • Stronger parent-child bond • Improve parent/caregiver mental health

High-Utilizer and Provider Outlier Program

- Molina consistently reviews core data sets on provider and member utilization
- Molina meets with providers with outlier utilization patterns to review trends, and jointly identify and design programs to curb over-utilization
- Molina conducts root cause analyses of factors leading to high utilization of behavioral inpatient services and will conduct meetings with providers who are serving members with high inpatient admissions and emergency room visits
- Molina reviews behavioral health inpatient readmission rates and conducts root cause analyses on the driving factors leading to high readmission rates; we'll work with you to implement clinical programs to decrease readmissions
- Providers should ensure they have practices in place to self-monitor utilization
- You can collaborate with Molina's BH and clinical teams to improve patient outcomes. Contact your provider relations rep.

Medical Necessity and Provider Responsibilities

Services must be individualized, clinically supported and coordinated

1

Medical Necessity

- Necessary to protect life, prevent significant illness or disability, or alleviate severe pain
- Specific and consistent with symptoms or confirmed diagnosis
- Consistent with generally accepted professional standards
- Delivered at the safe, effective and least costly appropriate level

2

Provider Responsibilities

- Complete required assessments before treatment planning
- Deliver only services supported by the treatment plan
- Maintain session-level documentation
- Communicate material changes in condition or treatment needs
- Support referrals, follow-up and transitions of care
- **Ensure members are seen within 7 days of discharge from inpatient care and following discharge from the emergency department**

3

Care Team Coordination

- Obtain the member or guardian's release before outreach
- Exchange relevant information with physical health and specialty providers
- Include family, school and community supports when appropriate
- Document referrals, outreach attempts and follow-up

Behavioral Health Assessment Process

Select the assessment that matches the member's clinical need and status. **Do not bill overlapping assessment services when the coverage policy identifies them as non-reimbursable on the same day.**

Brief BH Status Examination

H2010 HO

Clinical or psychiatric interview to assess behavioral stability or treatment status. Required before treatment planning unless a qualifying evaluation or in-depth assessment was completed in the prior six months.

In-depth Assessment

H0031 / H0001 HO or TS

Supports diagnosis, treatment-plan development or modification, and discharge criteria. Used when another assessment is insufficient, the member is high risk, prior outpatient treatment has been unsuccessful, or utilization is high.

Bio-Psychosocial Evaluation

H0031 / H0001 HN

Describes biological, psychological and social contributors, mental status, presenting problems, findings and preliminary recommendations. Not reimbursable on the same day as an in-depth assessment.

Treatment Plan Development and Review

The treatment plan is the clinical and documentation anchor

Required treatment plan elements

- Individualized and strength-based goals
- Measurable objectives with target dates
- Amount, frequency and duration of each service
- Diagnoses consistent with assessment findings
- Discharge criteria and aftercare planning
- Treating practitioner medical-necessity statement
- Required member or guardian and treatment-team signatures

Timing

- Plans are effective on the treating practitioner's signature date
- Florida Medicaid reimburses for services provided within 45 days of that signature

Review and update

- Review at least once every six (6) months or when significant changes occur.
- Document progress, findings, recommendations, changes, medical necessity and aftercare updates
- Explain when goals are not met but the plan is not changed.

Document, Adjust and Plan for Transition

Why this matters: Your records should show why services are needed, what was delivered, how the member is progressing, and how each treatment decision supports the next appropriate level of care

1 COORDINATE

Review records and releases, align goals, and document referrals and follow-up

2 MEASURE

Use progress data and clinical presentation to support medical necessity and service intensity

3 ADJUST

Increase, maintain, or reduce frequency and duration based on clinical need and documented outcomes

4 TRANSITION

Discuss discharge throughout care and connect the member to follow-up resources and natural supports

WHAT EACH SERVICE RECORD SHOULD SHOW

- Date of service, presenting concern, diagnosis, and service provided
- Progress toward measurable treatment-plan goals
- Medications, tests, referrals, and follow-up, when applicable
- A progress note for each service provided
- Provider signature and date within two business days

Document the service billed and the member's response. A note that only lists activities does not clearly demonstrate progress or continued need

DISCHARGE AND TRANSITIONS ARE APPROPRIATE WHEN:

Goals and needs are addressed, the member reaches baseline, the current level of care has provided maximum benefit, or another level of care is more appropriate

Member progress dictates titration of service duration and frequency and is to be adjusted as progress is made

Behavioral Health Prior Authorization Process

1. **Referral or Self-Referral**
   Routine outpatient BH may be self-referred **(not BNet);** PCP referral supports higher levels of care.

2. **Verify Benefit and Authorization Requirements**
   Check Availity for BH eligibility and which services require authorization

3. **Submit Request with Clinical Documentation through Availity**
   Assessment, diagnosis, treatment plan and records supporting the requested level of care

4. **Utilization Management Review**
   Molina BH clinicians review against medical necessity criteria; peer-to-peer discussion available

5. **Determination and Notification**
   Approval lists approved codes, units and effective dates; denials include appeal rights

6. **Deliver Services and Concurrent Review**
   Submit continued stay requests 30 days before authorized units or dates expire

Provider Responsibilities

- Emergency and crisis stabilization services do not require prior authorization
- Verify the authorization is active and matches the codes, units and dates of service
- Inpatient psychiatric, residential, PHP and IOP levels of care always require authorization
- BNet targeted case management follows the BNet clinical eligibility determination
- Coordinate with the PCP, CMS Plan Case Manager and BNet Care Coordinator
- Retain documentation supporting medical necessity in the member record

Authorization Decision Turnaround Times by Product Line

- Prior authorization: Required for most BA services before initiation and at each reauthorization (at least every 180 days. Providers may submit reauthorization requests as early as 30 days prior to the authorization end date, but no later than 10 days before the end date.
- To verify code-specific authorization requirements, use the Prior Authorization Code Lookup Tool at Prior Auth Look Up Tool
- All BA service requests are reviewed by Molina BCBAs and Child and Adolescent Psychiatrists

Product Line	Population Served	Auth Timeline
MMA	Medicaid Managed Care	**4 calendar days**
SMI	Serious Mental Illness- children and adults with severe psychiatric conditions	**4 calendar days**
CMS Title 19	Children's Medicaid- standard Medicaid children	**3 calendar days**
CMS Title 21	Children's Health Insurance Program (CHIP)	**3 calendar days**
MKP	Molina Marketplace Plan	**15 calendar day**

Need to Know:

- An expedited (or urgent) Request is a prior-authorization or service request that requires a faster-than-standard decision due to a potential serious risk to the member's health or safety.

- Routine BA reauthorizations generally do not meet this standard and should be submitted as standard requests within the timeframes above. Submitting routine requests as expedited can cause unnecessary review delays.

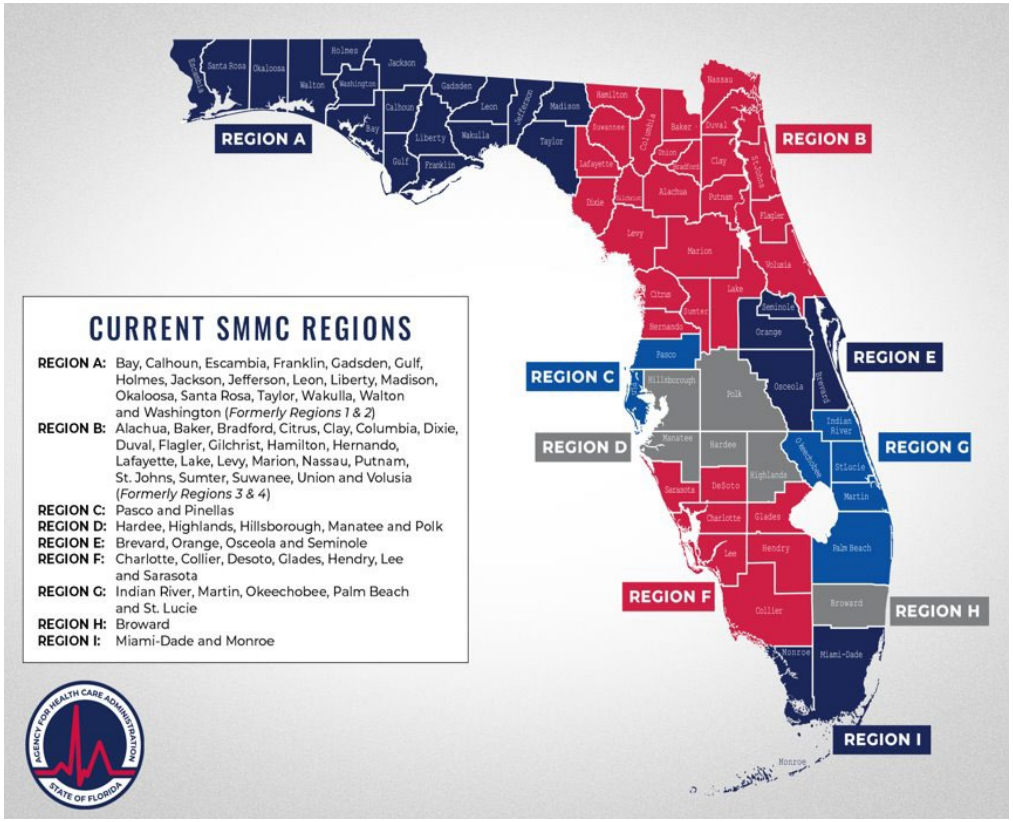
Do not initiate services before receiving written authorization from Molina. Services rendered without authorization are not reimbursable

Behavioral Health Prior Authorization and Management Process for Region A

- For all CMS Plan members residing in **AHCA Medicaid Region A (Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Okaloosa, Santa Rosa, Wakulla, Walton, and Washington counties)**, outpatient behavioral health and inpatient behavioral health services are managed and reimbursed through **Access Behavioral Health**
  - **To request an authorization**
    - Call Phone: 866-477-6725; or
    - Fax: 850-353-6041; or visit
    - Website: www.abhfl.org

- Behavioral Health Network (BNet) services are available for eligible CMS Health Plan Title XXI members enrolled in the BNet program and provide specialized behavioral health services for children and adolescents with qualifying behavioral health conditions.
  - Providers should contact the member's Care Manager to determine eligibility, enrollment status, and appropriate referral pathways

- Behavior Analysis (BA) services are carved out of both the BNet and Access Behavioral Health programs and should be submitted through Molina's standard authorization process



Children's Medical Services Plan BY MOLINA HEALTHCARE

MOLINA HEALTHCARE

Behavioral Health Network (BNet)

BNet is a statewide network of behavioral health service providers serving children ages 5 to 18 who have serious emotional disturbances or serious mental health or substance use disorders. **BNet enrolled members should only receive behavioral health services from BNet providers**

Key Eligibility Criteria for BNet:

- Children must meet ALL of the following:
- Ages 5 to 18 years old
- Have a serious emotional disturbance or serious mental health or substance use disorder
- NOT eligible for Medicaid
- Eligible for the KidCare subsidy program under Title XXI
- Enrolled in the Children's Medical Services (CMS) Title XXI Health Plan

Important exclusion: Children diagnosed with ADHD as their primary diagnosis do not qualify for BNet services

How BNet Works:

- Enrollment in BNet is voluntary
- Molina CMS Health Plan Care Manager assists families with the BNet program
- Regardless of BNet enrollment members still have access to all behavioral health services, expanded benefits andMolina programs
- When a member is enrolled in BNet services are transitioned to the BNet provider

This is a Referral-based program – Who can make a referral?

- Molina CMS health plan on behalf of eligible members
- **Schools, parents and local BNet providers do not make the referral**

Services Provided Through BNet:

- BNet Service Providers address children's needs via in-home, outpatient, individual and family counseling, psychiatry services,medication management, advocacy and wrap-around services to meet each child's social, educational, and nutritional needs.

***Note: BNet program will have a dedicated liaison to help coordinate BNet services.**

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Behavioral Health & BNet Provider Checklist

Use this checklist before, during and after treatment. **For BNet: Coordinate eligibility and referrals through Molina CMS Plan Care Management. Do Not direct families to self-refer**.

Before Services

- Verify eligibility and benefit
- Select the appropriate assessment
- Confirm required authorization using the plan's standard process
- Obtain consent and releases

During Treatment

- Deliver services within the treatment plan
- Complete compliant service documentation
- Measure progress and ongoing medical necessity
- Coordinate with the care team

At Review or Transition

- Update the plan for material changes
- Complete the six-month review when applicable
- Titrate services based on clinical need
- Document discharge and follow-up supports

Required Trainings

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Required Trainings: Self-Paced Modules

Training Resource	Training Topic	Who Should Complete	Timeline to Complete
Molina Provider Handbook Molina Florida Provider Handbook	• Fraud, Waste & Abuse (FWA) • Human Trafficking • Duty to Report • Alcohol/Substance Use	All contracted providers and applicable staff Alcohol/Substance Use - Providers participating in Healthy Behaviors Program	Upon onboarding and as applicable thereafter
Availity Availity Learning Center	• Introduction to CLAS • Health Outcomes • Persons with Disabilities • Providing Culturally & Linguistically Appropriate Services (CLAS) • Behavioral Health Training	All contracted providers and applicable staff	Complete during onboarding (within 30 days) and must sign the attestation form
AHCA Website Office of Risk Management and Patient Safety | Florida Agency for Health Care Administration	• Adverse Incident Reporting • Serious Adverse Event (SAE) Reporting & Root Cause Analysis (RCA)	Providers serving CMS Health Plan members Providers subject to adverse incident reporting requirements	Prior to serving CMS members and ongoing
HHAeXchange Knowledge Center	• EVV Requirements/Missed Visit Reporting	Home Health Agencies, Private Duty Nursing (PDN), Family Home Health Aides (FHHA), and applicable providers	Prior to service delivery and ongoing

Education through Psych Hub

Complimentary behavioral health training is available through PsychHub. Course availability and continuing education eligibility may vary by course and professional license.

Training Available at No Cost

Through Molina's partnership with PsychHub, network providers have complimentary access to an online library of digital mental health education

What Providers Can Access

- Online courses known as **Learning Hubs**
- Educational videos and companion resources
- Certificates of completion
- Continuing education credits for many courses
- Credits available for select clinical licenses, including social workers and nurses

How to Get Started

Throughout this toolkit, applicable PsychHub courses are identified for each behavioral health Topic

Create your complimentary account: Access the Molina PsychHub Learning Platform

Required Trainings: Behavior Health Specific

These trainings can be found in Psych Hub

Required Behavioral Health / Specialty Provider Competencies

Serious Mental Illness (SMI) Specialty Providers

Providers serving members in the SMI specialty product must have training and competencies related to:

- Assessment tools and assessment instruments
- Identification of unmet health and behavioral health needs
- Evidence-based practices
- Specialty population care management concepts

Child Welfare Behavioral Health Providers

Providers serving child welfare populations must have training in:

- Behavioral health assessment tools
- Identifying unmet behavioral health needs
- Evidence-based practices
- Dependency system knowledge
- Trauma-informed care

Provider Resources

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Provider Resources

Resource	Use For	Contact
CMS Plan Provider Website	CMS Plan implementation updates, provider training, FAQs and transition resources	CMS Plan Providers
Molina Provider Portal	Manuals, forms, training and roster updates	Molina Provider Portal
Availity Essentials / Provider Portal	Eligibility and benefits, prior authorization submission and status, claims and remittance tools	Molina Healthcare | Availity
Agency (AHCA) Website	CMS Plan transition guidance and provider alerts	CMS Plan Transition | Florida Agency for Health Care Administration
Provider Services	Primary contact for eligibility, authorizations, claims, portal support and general operational questions	(855) 322-4076 Monday–Friday, 8:00 a.m.–7:00 p.m. local time
Care Management	Member care coordination, plan-of-care collaboration and changes in condition	MemberSupportCMSFL@MolinaHealthcare.com Provider line: (855) 322-4076
Provider Contracting & Relations	CMS Plan participation, contracting status, network requests, provider education and unresolved operational issues	Contact your Provider Relations Representative Provider Relations Contact List
Claims Submission	Electronic or paper CMS Plan claim submission	Availity or clearinghouse: Payer ID 51062 Paper: Molina Healthcare of Florida, P.O. Box 22812, Long Beach, CA 90801
Provider Disputes	Claim payment or processing disagreements and supporting documentation	Availity or (855) 322-4076 Mail: Molina Healthcare of Florida Appeal and Grievance Unit, P.O. Box 36030, Louisville, KY 40233-6030
Capitol Bridge	Independent review of appeal decisions when a provider disagrees with Molina	(800) 889-0549 Email: FLCDR@capitolbridge.com

CMS Plan Vendors and Delegated Partners

Molina works with these partners to deliver CMS Plan services. Contact the vendor directly for the services they manage.

Vendor	What They Do	How Providers Use Them
Availity Essentials	Provider portal and EDI gateway	Eligibility, prior authorizations, claims and remittance; register at availity.com
SSI Claimsnet, LLC	Claims clearinghouse	Register online to submit EDI claims; Molina Payer ID 51062
Change Healthcare / ECHO Health	Electronic payments (EFT) and remittance (ERA)	Enroll immediately before your first Molina payment; (888) 834-3511
CVS Caremark	Pharmacy benefit manager	Pharmacy network, formulary and pharmacy claims; (800) 237-2767
Quest Diagnostics / LabCorp	Laboratory services	Direct outpatient lab work to these vendors; Quest (866) 697-8378, LabCorp (800) 845-6167
Access2Care / MTM Health	Non-emergency transportation	Members and staff schedule rides at (888) 298-4781
VSP and iCare Solutions	Vision services	VSP for Marketplace (800) 615-1883; iCare for MMA, Specialty and LTC (855) 373-7627
Coastal Care Services	DME, home health and home infusion	Practitioners: Order and authorize DME and home-based services; (855) 481-0505. DME, Home Health and Home Infusion provider types contract and credential through Coastal Care not Molina Healthcare
HHAeXchange	Electronic visit verification (EVV) for CMS Plan home-based services	Authorizations, scheduling, visit verification and billing; new agencies self-register and complete the required training
State Dental Health Plan	Dental services	Medicaid dental through the state plan; CHIP dental coordinated through Molina
Access Behavioral Health	Behavioral health management for AHCA Medicaid Region A	Outpatient and inpatient BH authorizations and reimbursement for Region A members; (866) 477-6725, fax (850) 353-6041, www.abhfl.org

Not sure who to call? *Start with Provider Services at (855) 322-4076 or your Provider Relations Representative.*