PROVIDER MANUAL

Molina Healthcare of South Carolina, Inc. (Molina Healthcare or Molina)

Molina Marketplace

2020

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

Last Updated: 7/2020

Molina Healthcare of South Carolina, Inc. Marketplace Provider Manual
Any reference to Molina Healthcare members means Molina Healthcare Marketplace members.

CONTENTS

1. ADDRESSES AND PHONE NUMBERS

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

Provider Services Department

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

Phone: (855) 237-6178
Provider Portal: https://provider.MolinaHealthcare.com

Member Services Department

The Member Services Department handles all telephone and written inquiries regarding member Claims, benefits, eligibility/identification, selecting or changing Primary Care Providers (PCP), and member complaints. Member Services Representatives are available Monday through Friday from 8:00 a.m. to 6:00 p.m., local time, excluding holidays.

Phone: (855) 885-3176
Hearing Impaired TTY/TDD: 711 Relay

Claims Department

Molina requires Participating Providers to submit Claims electronically (via a clearinghouse or Molina's Provider Portal whenever possible.

- Access the Provider Portal (https://provider.MolinaHealthcare.com)
- EDI Payer ID 46299

To ensure satisfactory service to all of our callers, we may limit the number of claim status requests per call. We encourage all providers to use the Molina Provider portal, where claim status can be obtained 24/7.Claims Recovery Department

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

Molina Healthcare of South Carolina, Inc.
PO Box 602960 Charlotte, NC 28260-2960
Phone: (855) 237-6178

Compliance and Fraud AlertLine

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

Confidential
Compliance Official
Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802

Phone: (866) 606-3889
Email: https://MolinaHealthcare.AlertLine.com

Credentialing Department

The Credentialing Department verifies all information on the Provider Application prior to contracting and re-verifies this information every three (3) years or sooner, depending on Molina's Credentialing criteria. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Molina network.

Phone: (855) 237-6178

24-Hour Nurse Advice Line

This telephone-based nurse advice line is available to all Molina members. Members may call anytime they are experiencing symptoms or need health care information.

Registered nurses are available twenty-four (24) hours a day, seven (7) days a week to assess symptoms and help make good health care decisions.

English Line	:	(844) 800-5155
Spanish Line	:	(888) 648-3537
TTY English	:	(866) 735-2929
TTY Spanish	:	(866) 833-4703

Healthcare Services Department

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

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

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

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

- Submit requests directly to Molina via the Provider Portal. See Molina's Provider Portal Quick Reference Guide or contact your Provider Services Representative for registration and submission guidance.
- Submit requests via 278 transactions. See the EDI transaction section of Molina's website for guidance.

Provider Portal : https://provider.MolinaHealthcare.com
Phone : (855) 237-6178
Fax : (866) 423-3889

Healthcare Services Authorizations & Inpatient Census

Provider Portal : https://provider.MolinaHealthcare.com

Address : Molina Healthcare of South Carolina, Inc.
PO Box 40309
North Charleston, SC 29423-0309

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

Health Management Department

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

Phone : (855) 237-6178
Fax : (843) 740-1773

Behavioral Health

Molina manages all components of our Covered Services for behavioral health. For member behavioral health needs, please contact us directly at (855) 237-6178.

Pharmacy Department

Pharmacy services are covered through CVS Caremark. A list of in-network pharmacies is available at: ProviderSearch.MolinaHealthcare.com, or by contacting Molina.

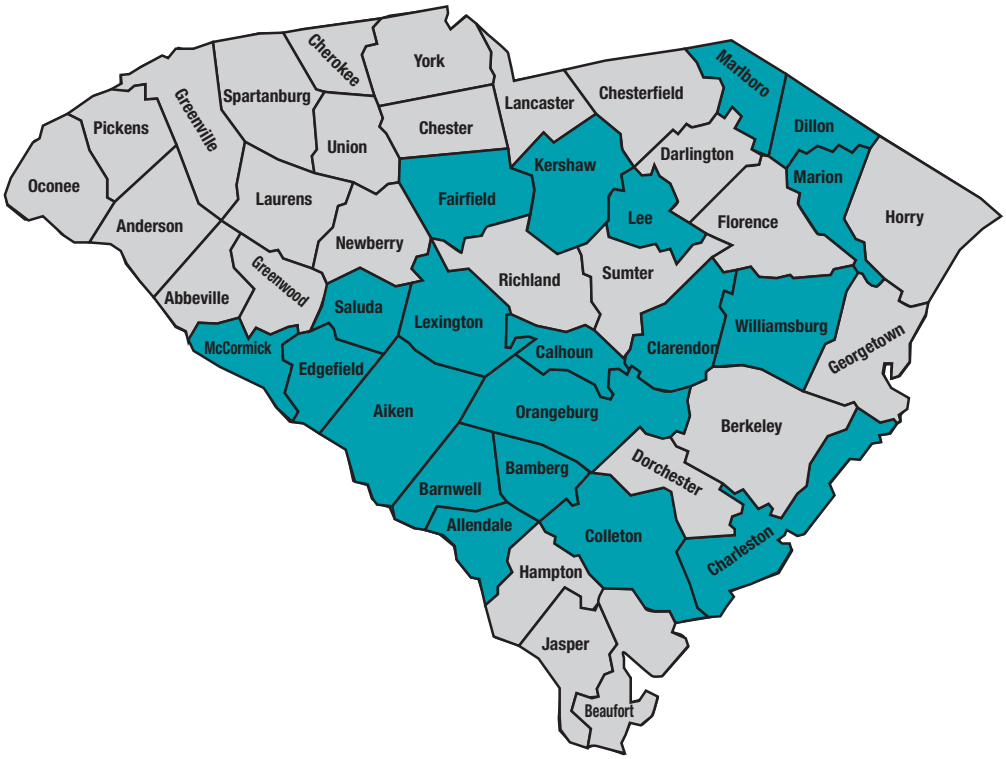
Phone : (855) 237-6178

Quality Improvement

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

Phone : (855) 237-6178

Molina Healthcare of South Carolina, Inc. Service Area



2. PROVIDER RESPONSIBILITIES

Nondiscrimination of Healthcare Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act, which includes notification of nondiscrimination and instructions for accessing language services in all significant member materials, physical locations that serve our members, and all Molina website home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina requires Providers to deliver services to Molina members without regard to race, color, national origin, age, disability, religion, genetic information, military status, ancestry, health status, sex or need for health services. This includes gender identity, sexual orientation, pregnancy and sex stereotyping. Providers must post a non- discrimination notification in a conspicuous location of their office along with translated non-English taglines in the top fifteen (15) languages spoken in the State to ensure Molina members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

Additionally, Participating Providers or contracted medical groups/IPAs may not limit their practices because of a member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care. Providers must not discriminate against enrollees based on their payment status and cannot refuse to serve members because they receive assistance from a State Medicaid Program.

Section 1557 Investigations

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

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

Toll Free: (866) 606-3889
Hearing Impaired TTY/TDD: 711
On Line: https://MolinaHealthcare.AlertLine.com
Email: civil.rights@MolinaHealthcare.com

Facilities, Equipment and Personnel

The Provider's facilities, equipment, personnel and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable

legal requirements including the accessibility requirements of the Americans with Disabilities Act (ADA).

Provider Data Accuracy and Validation

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

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

Providers must validate the Provider Online Directory (POD) information at least quarterly for correctness and completeness. Providers must notify Molina in writing (some changes can be made online) at least thirty (30) days in advance of changes such as, but not limited to:

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

Please visit our Provider Online Directory (POD) at https://providersearch.MolinaHealthcare.com to validate and correct your information. A convenient Provider web form can be found on the POD and on the Provider Portal at https://provider.MolinaHealthcare.com. You may also notify your Provider Services Representative if your information needs to be updated or corrected.

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

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

Molina Electronic Solutions Participation

Molina requires Providers to utilize electronic solutions and tools whenever possible.

Molina requires all contracted Providers to participate in and comply with Molina's Electronic Solution Requirements, which include, but are not limited to, electronic submission of prior authorization requests, prior authorization status inquiries, health plan access to electronic medical records (EMR), electronic Claims submission and claims status, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic Claims Appeal and registration for and use of Molina's Provider Portal.

Electronic Claims include Claims submitted via a clearinghouse using the EDI process and claims submitted through the Molina Provider Portal.

Any Provider entering the network as a Contracted Provider will be required to comply with Molina's Electronic Solution Policy by enrolling for EFT/ERA payments and registering for Molina's Provider Portal within thirty (30) days of entering the Molina network.

Molina is committed to complying with all HIPAA Transactions, Code Sets, and Identifiers (TCI) standards. Providers must comply with all HIPAA requirements when using electronic solutions with Molina. Providers must obtain a National Provider Identifier (NPI) and use their NPI in HIPAA Transactions, including Claims submitted to Molina. Providers may obtain additional information by visiting Molina's HIPAA Resource Center located on our website at www.MolinaHealthcare.com.

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:

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

Electronic Claims Submission Requirement

Molina requires participating Providers to submit Claims electronically whenever possible. Electronic Claims submission provides significant benefits to the Provider including:

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

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the Provider Portal. See our Provider Portal Quick Reference Guide https://provider.MolinaHealthcare.com or contact your Provider Services Representative for registration and Claim submission guidance.
- Submit Claims to Molina through your EDI clearinghouse using Payer ID 46299, refer to our website www.MolinaHealthcare.com for additional information.

While both options are embraced by Molina, submitting Claims via Molina's Provider Portal (available to all Providers at no cost) offers a number of additional Claims processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper Claims.

Provider Portal Claims submitting benefits include:

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

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

Electronic Payment (EFT/ERA) Requirement

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

Below is the link to register with Change Healthcare ProviderNet to receive EFTs/ERAs. Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina's website: www.MolinaHealthcare.com.

Any questions during this process should be directed to Change Healthcare Provider Services at wco.provider.registration@changehealthcare.com or (877) 389-1160.

Provider Portal

Providers are required to register for and utilize Molina's Provider Portal. Molina's Provider Portal is an easy to use, online tool available to all of our Providers at no cost. The Provider Portal offers the following functionality:

- Verify and print member eligibility
- View benefits, covered services and member health record
- View Member roster of assigned Molina members for PCP(s)
- Claims Functions
    - Professional and Institutional Claims (individual or multiple claims)
    - Receive notification of Claims status change
    - Correct Claims
    - Void Claims
    - Add attachments to previously submitted Claims
    - Check Claims status
    - Export Claims reports
    - Create and Manage Claim Templates
    - Open Saved Claims
- Prior Authorizations/Service Requests
    - Create and submit Prior Authorization/Service Requests
    - Check status of Authorization/Service Requests
    - Receive notification of change in status of Authorization/Service Requests
    - Create Authorization/Service Request Templates
- View HEDIS® Scores and compare to national benchmarks
- Appeals
    - Create and submit a Claim Appeal
    - Add Appeal attachments to Appeal
    - Receive Email Confirmation

Third Party Billers can access and utilize all Claim Functions. Third Party Billers do not have to phone in to get Claim updates and to make changes. All Claim functionalities are now available for Third Party Billers online at Molina's Provider Portal.

Balance Billing

Providers contracted with Molina cannot bill the member for any Covered Services beyond applicable copayments, deductibles or coinsurance. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

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

For additional information please refer to the Compliance and Claims and Compensation sections of this Provider Manual.

Member Rights and Responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in Molina's member materials (such as the Evidence of Coverage).

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

Member Information and Marketing

Any written informational or marketing materials directed to Molina members must be developed and distributed in a manner compliant with all State and Federal Laws and regulations and approved by Molina prior to use.

Please contact your Provider Services Representative for information and review of proposed materials.

Member Eligibility Verification

Possession of a Molina ID Card does not guarantee member eligibility or coverage. Providers should verify eligibility of Molina members prior to rendering services.

Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

For additional information please refer to the Eligibility, Enrollment, Disenrollment and Grace Period section of this Provider Manual.

Member Cost Share

Providers should verify the Molina Member's Annual Out-of-Pocket expense status prior to requiring the member to pay co-pay, co-insurance, deductible or other cost sharing that may be applicable to the member's specific Benefit Plan. Marketplace plans have an annual limit that frees the member from further out-of-pocket charges once reached during that calendar year.

Healthcare Services (Utilization Management and Case Management)

Providers are required to participate in and comply with Molina's Utilization Management and Case Management programs, including all policies and procedures regarding Molina's facility admission, prior authorization, and Medical Necessity review determination procedures. Providers will also cooperate with Molina in audits to identify, confirm, and/or assess utilization levels of covered services.

For additional information please refer to the Healthcare Services section of this Provider Manual.

In Office Laboratory Tests

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

For more information about In-Network Laboratory Providers, please consult the Molina Provider Online Directory (https://providersearch.MolinaHealthcare.com). For testing available through In-Network Laboratory Providers. For a list of In-Network Laboratory Provider patient service centers, please reach out to the In-Network Laboratory Provider.

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

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

Referrals

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

Providers should direct Molina members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed (if applicable) with Molina. In the case of Emergency Services, Providers may direct members to an appropriate service including, but not limited to, primary care, urgent care and Emergency Services. There may be circumstances in which referrals may require an out- of-network Provider. Prior authorization will be required from Molina except in the case of Emergency Services. For additional information please refer to the Healthcare Services section of this Provider Manual.

PCPs are able to refer a member to an in-network specialist for consultation and treatment without a prior authorization.

Treatment Alternatives and Communication with Members

Molina endorses open provider- member communication regarding appropriate treatment alternatives and any follow up care. Molina promotes open discussion between Provider and members regarding Medically Necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate any and all treatment options to members regardless of benefit coverage limitations.

Providers are also encouraged to promote and facilitate training in self-care and other measures members may take to promote their own health.

Pharmacy Program

Providers are required to adhere to Molina's drug formularies and prescription policies. For additional information please refer to the Pharmacy section of this Provider Manual.

Participation in Quality Programs

Providers are expected to participate in Molina's Quality Programs and collaborate with Molina in conducting peer review and audits of care rendered by Providers. Such participation includes, but is not limited to:

- Access to Care Standards
- Site and Medical Record-Keeping Practice Reviews
- Delivery of Patient Care Information

For additional information please refer to the Quality section of this Provider Manual.

Compliance

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

Confidentiality of Member Health Information and HIPAA Transactions

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

Participation in Grievance and Appeals Programs

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

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

Participation in Credentialing

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

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

More information about Molina's Credentialing program is available in the Credentialing section of this Provider Manual.

Delegation

Delegated entities must comply with the terms and conditions outlined in Molina's Delegation Policies and Delegated Services Addendum. Please see the Delegation section of this Provider Manual for more information about Molina's delegation requirements and delegation oversight.

3. CULTURAL COMPETENCY AND LINGUISTIC SERVICES

Background

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

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

Nondiscrimination of Healthcare Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the ACA, which includes notification of nondiscrimination and instructions for accessing language services in all significant member materials, physical locations that serve our members, and all Molina website home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina requires Providers to deliver services to Molina members without regard to race, color, national origin, age, disability or sex. This includes gender identity, sexual orientation, pregnancy and sex stereotyping. Providers must post a non-discrimination notification in a conspicuous location in their office along with translated non-English taglines in the top fifteen (15) languages spoken in the State to ensure Molina members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

Additionally, Participating Providers or contracted medical groups/Independent Physician Associations (IPAs) may not limit their practices because of a member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.

Providers must not discriminate against enrollees based on their payment status and cannot refuse to serve members because they receive assistance with Medicare cost-sharing from a State Medicaid Program.

Providers can refer Molina members who are complaining of discrimination to the Molina Civil Rights Coordinator at: (866) 606-3889, or TTY, 711.

Members can also email the complaint to civil.rights@MolinaHealthcare.com.

Members can mail their complaint to Molina at:
Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802

Members can also file a civil rights complaint with the U.S. Department of Health and Human Services, OCR. Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html. The form can be mailed to:

U.S. Department of Health and Human Services at
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Members can also send it to a website through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf.

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

Should you or a Molina member need more information you can refer to the Health and Human Services website for more information: https://www.federalregister.gov/d/2016-11458

Cultural Competency

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

Provider and Community Training

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

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

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

Integrated Quality Improvement – Ensuring Access

Molina ensures member access to language services such as oral interpretation, American Sign Language (ASL) and written translation. Molina must also ensure access to programs, aids, and services that are congruent with cultural norms. Molina supports members with disabilities and assists members with LEP.

Molina develops member materials according to Plain Language Guidelines. Members or Providers may also request written member materials in alternate languages and formats (i.e., braille, audio, large print), leading to better communication, understanding and member satisfaction. Online materials found on www.MolinaHealthcare.com and

information delivered in digital form meet Section 508 accessibility requirements to support members with visual impairments.

Key member information, including Appeal and Grievance forms, are also available in threshold languages on the Molina member website.

Program and Policy Review Guidelines

Molina conducts assessments at regular intervals of the following information to ensure its programs are most effectively meeting the needs of its members and Providers:

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

Access to Interpreter Services

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

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

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

Documentation

As a contracted Molina Provider, your responsibilities for documenting member language services/needs in the member's medical record are as follows:

- Record the member's language preference in a prominent location in the medical record. This information is provided to you on the electronic member lists that are sent to you each month by Molina.
- Document all member requests for interpreter services.
- Document who provided the interpreter service. This includes the name of Molina's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code and vendor.
- Document all counseling and treatment done using interpreter services.
- Document if a member insists on using a family member, friend or minor as an interpreter, or refuses the use of interpreter services after notification of his or her right to have a qualified interpreter at no cost.

Members who are Deaf or Hard of Hearing

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

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

Molina will provide face-to-face service delivery for ASL to support our members who are deaf or hard of hearing. Requests should be made three (3) business days in advance of an appointment to ensure availability of the service. In most cases, members will have made this request via Molina Member Services.

Nurse Advice Line

Molina provides twenty-four (24) hours/seven (7) days a week Nurse Advice Services for members. The Nurse Advice Line provides access to twenty-four (24) hour interpretive services. Members may call Molina's Nurse Advice Line directly - English line (844) 800-5155 or TTY/TDD 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

4. MEMBER RIGHTS AND RESPONSIBILITIES

Providers must comply with the rights and responsibilities of Molina members as outlined in the Molina Evidence of Coverage (EOC).

EOCs are available on the Molina's member website. Member Rights and Responsibilities are outlined under the heading "your Rights and Responsibilities" within the EOC document.

State and Federal Law requires that health care Providers and health care facilities recognize member rights while the members are receiving medical care, and that members respect the health care Provider's or health care facility's right to expect certain behavior on the part of the members.

For additional information, please contact Molina at (855) 237-6178. This number is available on all business days from 8:00 a.m. to 5:00 p.m. TTY users, please call 711.

Second Opinions

If a member does not agree with their Provider's plan of care, they have the right to request a second opinion from another Provider. Members should call Member Services to find out how to get a second opinion. Second opinions may require Prior Authorization.

5. ELIGIBILITY, ENROLLMENT, DISENROLLMENT AND GRACE PERIOD

Enrollment

The Centers for Medicare and Medicaid Services (CMS) is the program which implements the Health Insurance Marketplace as part of the Affordable Care Act. It is administered by the South Carolina Department of Insurance.

To enroll with Molina, the member, their representative, or their responsible parent or guardian must follow enrollment process established by CMS. CMS will enroll all eligible members with the health plan of their choice.

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

Effective Date of Enrollment

Coverage shall begin as designated by the Marketplace Exchange on the first day of a calendar month. If the enrollment application process is completed by the 15th of the month, the coverage will be effective on the first day of the next month. If enrollment is completed after the 15th of the month, coverage will be effective on the first day of the second month following enrollment.

Newborn Enrollment

When a Molina Marketplace Subscriber or their spouse gives birth, the newborn is automatically covered under the Subscriber's policy with Molina for the first thirty-one

(31) days of life. In order for the newborn to continue with Molina coverage past this time, the infant must be enrolled through the Marketplace Exchange with Molina on or before sixty (60) days from the date of birth.

PCP's are required to notify Molina via the Pregnancy Notification Report immediately after the first prenatal visit and/or positive pregnancy test for any Molina member presenting themselves for health care services.

Inpatient at Time of Enrollment

With member assistance, Molina may reach out to any prior Insurer (if applicable) to determine the member's prior Insurer's liability for payment of Inpatient Hospital Services through discharge of any Inpatient admission. If there is no transition of care provision through member's prior Insurer or member did not have coverage through an Insurer at the time of admission, Molina would assume responsibility for Covered Services upon the effective date of member's coverage with Molina, not prior.

Eligibility Verification

Health Insurance Marketplace Programs

Payment for services rendered is based on enrollment status and coverage selected. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

Eligibility Listing for Molina Marketplace Programs

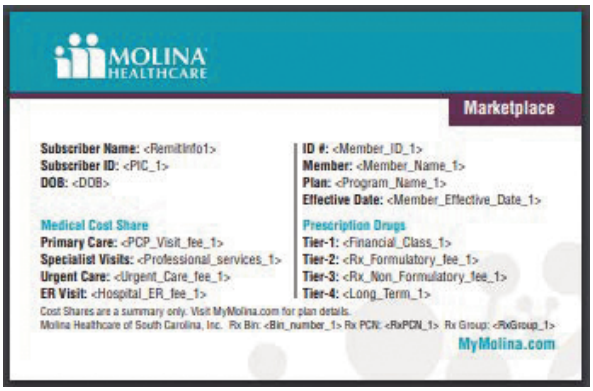
Providers who contract with Molina may verify a member's eligibility for specific services and/or confirm PCP assignment by checking the following:

- Molina Provider Portal https://provider.MolinaHealthcare.com.
- Molina Provider Services automated IVR system at (855) 237-6178.

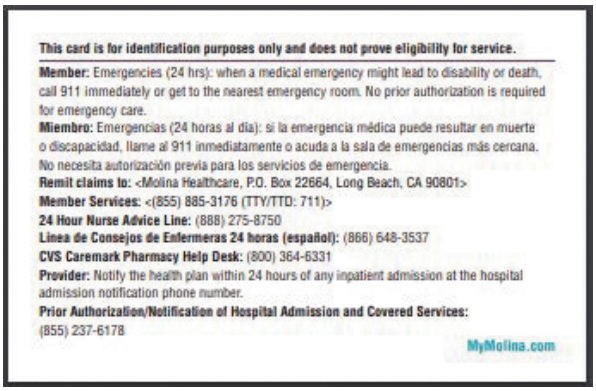
Possession of a Marketplace ID Card does not mean a recipient is eligible for Marketplace services. A Provider should verify a recipient's eligibility each time the recipient presents to their office for services. The verification sources can be used to verify a recipient's enrollment in a Molina Marketplace plan.

Identification Cards

Molina Healthcare of South Carolina, Inc. Sample Member ID card
Card Front



Card Back



Members are reminded in their Agreement/COC/EOC/Policy to carry ID cards with them when requesting medical or pharmacy services. It is the Provider's responsibility to ensure Molina member are eligible for benefits and to verify PCP assignment, prior to rendering services. Unless an Emergency Medical Condition exists, Providers may refuse service if the member cannot produce the proper identification and eligibility cards.

Disenrollment

Voluntary Disenrollment

Members have the right to terminate coverage for any reason at any time. However, beyond the open-enrollment period, if a member elects to terminate coverage with Molina Marketplace, they are not eligible to re-enroll with another health plan until the following year's open-enrollment period unless there is a life event, and they qualify for a Special Enrollment Period (SEP) or if they are American Indian or Alaska Native. Members may discontinue Molina coverage by contacting the Marketplace Exchange.

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

Involuntary Disenrollment

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

- Delinquency of payment, past defined grace period(s).
- Member has moved out of the Service Area.
- Member death.
- Member's continued enrollment seriously impairs the ability to furnish services to this
- member or other members.
- Member demonstrates a pattern of disruptive or abusive behavior that could be construed as non-compliant and is not caused by a presenting illness (this may not apply to member refusing medical care.)
- Member's utilization of services is fraudulent or abusive
- Member ages out of coverage (e.g., dependent child age > twenty-six (26), child- only age > twenty-one (21).)

PCP Assignment

Molina will offer each member a choice of Primary Care Providers (PCPs). After making a choice, each member will have a single PCP. Molina will assign a PCP to those member who did not choose a PCP at the time of Molina selection. Molina will take into consideration the member's last PCP (if the PCP is known and available in Molina 's contracted network), closest PCP to the member's home address, ZIP code location, keeping Children/Adolescents within the same family together, age (adults versus Children/Adolescents) and gender (OB/GYN). Molina will allow pregnant members to choose the Health Plan's obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP.

PCP Changes

Members can change their PCP at any time. All changes completed by the 25th of the month will be in effect on the first day of the following calendar month. Any changes requested on or after the 26th of the month will be in effect on the first day of the second calendar month.

Grace Period

Definitions

APTC member: A member who receives advanced premium tax credits (premium subsidy), which helps to offset the cost of monthly premiums for the member.

Non-APTC member: A member who is not receiving any advanced premium tax credits and is therefore solely responsible for the payment of the full monthly premium amount.

Member: An individual, including any dependents, enrolled in Molina Marketplace. This term includes both APTC members and Non-APTC members.

Summary

The Affordable Care Act mandates that all qualified health plans offering insurance through the Health Insurance Marketplace provide a grace period of three (3) consecutive months to APTC members who fail to pay their monthly premium by the due date. Molina Marketplace also offers a grace period in accordance with State Law to Non-APTC members who fail to pay their monthly premium by the due date. To qualify for a grace period, the member must have paid at least one full month's premium within the benefit year. The grace period begins on the first day of the first month for which the member's premium has not been paid. The grace period is not a "rolling" period. Once the member enters the grace period, they have until the end of that period to resolve the entire outstanding premium balance; partial payment will not extend the grace period.

Grace Period Timing

Non-APTC members

Non-ATPC members are granted a thirty-one (31) day grace period, during which they may be able to access some, or all services covered under their benefit plan. If the full past-due premium is not paid by the end of the grace period, the Non-APTC member will be terminated retroactive to the last day of the month prior to the grace period.

APTC members

APTC members are granted a three (3) month grace period. During the first month of the grace period Claims and authorizations will continue to be processed, including Pharmacy Claims. Services, authorization requests and Claims may be denied or have certain restrictions during the second and third months of the grace period. If the APTC member's full past-due premium is not paid by the end of the third month of the grace period, the APTC member will be retroactively terminated to the last day of the first month of the grace period.

Eligibility Messages

When a member is in the grace period, Molina Healthcare, Inc. ("Molina") will include an eligibility message on the Provider Portal, interactive voice response (IVR) and in the call centers. This message will provide information about the member's grace period status, including which month of the grace period that the member is in the grace period (second or third) as well as information about how authorizations and Claims will be processed during this time. Providers should verify both the eligibility status AND any service messages when checking a member's eligibility. For additional information about how authorizations and Claims will be processed during this time, please refer to the Member Evidence of Coverage, or contact Molina's Provider Services Department at (888) 560-5716.

Notification

All members will be notified upon entering the grace period. Additionally, when an APTC member enters the grace period, their eligibility status becomes available on the Provider Portal. The online eligibility notification will inform Providers as follows:

- Members who receive APTC and have entered the first month of the grace period will not have any service restrictions. Therefore, the message that Providers will see upon checking the Provider Portal will read as follows: No Enrollment Restrictions.
- Providers will be notified and are able to check that the APTC member entered the second or third months of the grace period.
- All Providers and specifically, Providers who have submitted Claims for the APTC member in the two (2) months prior to the start of the grace period will be notified and are able to check that the APTC member entered the second or third months of the grace period.
- Providers will be notified and are able to check if the APTC member is in the second or third months of the grace period before services are rendered and before submitting claims.

The online eligibility notification will advise Providers that services rendered during the second and third months of the grace period may be denied if the premium is not paid in full prior to the expiration of the third month of the grace period.

Prior Authorizations

All authorization requests will be reviewed based on Medical Necessity and will expire after thirty (30) days. If a request for a prior authorization is made, the Provider will receive the following disclaimer:

"Prior Authorization is a review of medical necessity and is not a guarantee of payment for services. Payment will be made in accordance with a determination of the member's eligibility on the date of service (for Molina Marketplace members, this includes grace period status), benefit limitations/exclusions and other applicable standards during the claim review, including the terms of any applicable provider agreement. If permitted under State law, Molina Healthcare will pend claims for services provided to Marketplace members in months 2 & 3 of the Federally-required grace period until such time as all outstanding premiums due are received or the grace period expires, whichever occurs first. For additional information on a Marketplace member's grace period status, please contact Molina Healthcare."

APTC Members

Authorization requests received during the first month of an APTC member's grace period will be processed according to Medical Necessity standards. Authorizations during the second and third month of the APTC member's grace period will process in accordance with State and Federal statutes and regulations and according to Medical Necessity. Authorizations issued during this time will include notification that the APTC member is in the second or third month of the grace period and Claims for the authorized services may be denied if the premium is not paid in full by the end of the grace period.

Non-APTC Members

Authorization requests received during a Non-APTC member's grace period will be processed according to Medical Necessity standards.

Claims Processing

APTC Members

First Month of Grace Period: Clean Claims received for services rendered during the first month of a grace period will be processed using Molina's standard processes and in accordance with State and Federal statutes and regulations and within established turn-around-times.

Second/Third Month of Grace Period: Clean Claims received while the APTC member is in the grace period for services rendered during the second and third months of an APTC member's grace period will be processed according to Molina's standard processes, within established turnaround-times, and in accordance with State and Federal statutes and regulations. In the event that the APTC member is terminated for non-payment of the full premium prior to the end of the grace period, Molina will retroactively deny Claims for services rendered in the second and third months of the grace period and will issue a re-coup notice to the Provider(s) if appropriate. Pharmacy Claims will be processed based on program drug utilization review and formulary edits; the APTC member will be charged one-hundred percent (100%) of the discounted cost for prescriptions filled during the second and third months of the grace period.

Non-APTC Members

Clean Claims received for services rendered during the grace period will be processed using Molina's standard processes and in accordance with State and Federal statutes and regulations and within established turn-around-times.

6. BENEFIT AND COVERED SERVICES

Molina covers the services described in the Summary of Benefits and Evidence of Coverage (EOC) documentation for each Molina Marketplace plan type. If there are questions as to whether a service is covered or requires prior authorization, please contact Molina at (855) 237-6178. This number is available on all business days from 8:00 a.m. to 5:00 p.m.

Member Cost Sharing

Cost Sharing is the Deductible, Copayment, or Coinsurance that members must pay for Covered Services provided under their Molina Marketplace plan. The Cost Sharing amount members will be required to pay for each type of Covered Service is summarized on the member's ID card. Additional detail regarding cost sharing listed in the Schedule of Benefits. Cost Sharing applies to all Covered Services except for preventive services included in the Essential Health Benefits (as required by the Affordable Care Act). Cost Sharing towards Essential Health Benefits may be reduced or eliminated for certain eligible members, as determined by Marketplace's rules.

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

Link Benefit Documents

The following web link provides access to the Summary of Benefits guides and Evidence of Coverage (EOC) documents for the Molina Marketplace products offered in South Carolina.

https://www.molinahealthcare.com/members/sc/en-US/hp/marketplace/plans/Pages/View-Our-2020-Plans.aspx

Detailed Benefit Information

Detailed information about benefits and services can be found in the Schedule of Benefits booklets made available to Molina Marketplace members via the Molina Member Portal. EOCs are available to Providers via the Provider Portal. Link: www.MolinaHealthcare.com/provider

Obtaining Access to Certain Covered Services
Prescription Drugs

Prescription drugs are covered by Molina, via our pharmacy vendor, CVS Caremark. A list of in-network pharmacies is available on the www.MolinaHealthcare.com website, or by contacting Molina. members must use their Molina ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, and its limitations, is available by contacting Molina at (855) 237-6178 or at www.MolinaMarketplace.com.

Non-Formulary Drug Exception Request Process

There are two (2) types of requests for clinically appropriate drugs that are not covered under the member's Marketplace plan type:

- "Expedited Exception Request" for urgent circumstances that may seriously jeopardize life, health or ability to regain maximum function, or for undergoing current treatment using non-Drug Formulary drugs.
- "Standard Exception Request"
- The member and/or member's representative and the prescribing Provider will be notified of Molina's decision no later than:
    - Twenty-four (24) hours following receipt of request for Expedited Exception Request
    - Seventy-two (72) hours following receipt of request for Standard Exception Request
- If the initial request is denied, an external review may be requested. The member and/or member's representative and the prescribing Provider will be notified of the external review decision no later than:
    - Twenty-four (24) hours following receipt of the request for external review of the Expedited Exception Request
    - Seventy-two (72) hours following receipt of the request for external review of the Standard Exception Request

Injectable and Infusion Services

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

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

Access to Mental Health and Substance Use Disorder Treatment Services

Members in need of Mental Health or Substance Use Disorder Treatment Services can be referred by their PCP for services by calling Molina's Provider Services at (855) 237- 6178. Molina's Nurse Advice Line is available twenty-four (24) hours a day, seven (7) days a week for mental health or substance abuse needs. The services members receive will be confidential. Additional detail regarding Covered Services and any limitations can be obtained in the EOCs linked above, or by contacting Molina. All

outpatient professional mental health and substance use disorder treatment services will be charged the primary care copay equivalent.

Emergency Mental Health or Substance Use Disorder Treatment Services

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

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

Out of Area Emergencies

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

- Go to the nearest emergency room.
- Call the number on ID card.
- Call member's PCP and follow-up within twenty-four (24) to forty-eight (48) hours.

For out-of-area Emergency care, plans will be made to transfer members to an in- network facility when member is stable.

Obtaining Mental Health or Substance Use Disorder Treatment Services

Please call the appropriate member Services or Provider Services number to find a mental health or substance abuse Provider.

Emergency Transportation

When a member's condition is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while in route to the nearest appropriate facility, emergency transportation is thus required. Emergency transportation includes, but is not limited to, ambulance, air or boat transports.

Non-Emergency Medical Transportation

Molina covers non-routine, non-Emergency Medically Necessary ground transportation, when Molina determines such transportation is needed within Molina's Service Area to transfer the member from one medical facility to another. Examples of this are from one hospital to another hospital, from a hospital to a skilled nursing facility or hospice. Non- Emergency medical transportation is provided by wheelchair lift equipped vehicle, litter/stretcher van or non-Emergency ambulance (both advanced life support and basic life support). When non-Emergency medical transportation is needed, Molina will arrange for the transportation to be provided by one of our Participating Provider transportation vendors. Please note, this is not a service for which members can self-refer, and any services not arranged by Molina will not be covered.

Telehealth and Telemedicine Services

- You may obtain Covered Services by Participating Providers, through the use of Telehealth and Telemedicine services. Not all Participating Providers offer these services. For more information, please refer to Telehealth and Telemedicine services in the definitions section. The following additional provisions that apply to the use of Telehealth and Telemedicine services:
- Services must be obtained from a Participating Provider.
- Services are meant to be used when care is needed now for non-emergency medical issues.
- Services are a method of accessing Covered Services, and not a separate benefit.
- Services are not permitted when the member and Participating Provider are in the same physical location.
- Services do not include texting, facsimile or email only.
- Member cost sharing associates to the Schedule of Benefits, based upon the Participating Provider's designation for Covered Services. (i.e., Primary Care, Specialist or Other Practitioner).
- Covered Services provided through Store and Forward technology, must include an in-person office visit to determine diagnosis or treatment.

Preventive Care

Preventive Care Guidelines are located on the Molina website. Please use the link below to access the most current guidelines: www.MolinaHealthcare.com/provider We need your help conducting these regular exams in order to meet the targeted State and Federal standards. If you have questions or suggestions related to well child care, please call our Health Education line at (855) 237-6178.

Emergency Services

Emergency Services means: health care services needed to evaluate, stabilize or treat an Emergency Medical Condition.

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

Nurse Advice Line

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

English Phone	:	(844) 800-5155
Spanish Phone	:	(866) 648-3537
TTY/TDD	:	711 Relay
Or		(866) 735-2929 (English)
		(866) 833-4703 (Spanish)

Molina is committed to helping our members:

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

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

Health Management Programs

Molina's health management programs provide patient education information to members and facilitate Provider access to chronic disease programs and services.

For additional information on health management programs please refer to the Healthcare Services section of this Provider Manual.

7. HEALTHCARE SERVICES

Introduction

Healthcare Services is comprised of Utilization Management and Case Management departments that work together to achieve an integrated model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, member -centric care environment for at-risk members supports better health outcomes. Molina provides case management services to members using processes designed to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services.

Elements of the Molina utilization management program include pre-service authorization review and inpatient authorization management that includes pre- admission, admission and concurrent review, medical necessity review, and restrictions on the use of out of network Providers.

Utilization Management (UM)

Molina's UM Department is designed to provide comprehensive health care management. This focus, from prevention through treatment, benefits the entire care delivery system by effectively and efficiently managing existing resources to ensure quality care. It also ensures that care is both medically necessary and demonstrates an appropriate use of resources based on the severity of illness and the site of service.

Molina works in partnership with members and Providers to promote a seamless delivery of health care services. The UM team works closely with the Case Management team to ensure members receive the support they need when moving from one care setting to another or when complexity of care and services is identified. Molina's UM program ensures appropriate and effective utilization of services by:

- Managing benefits effectively and efficiently to ensure appropriate use of health care services.
- Identifying the review criteria, information sources, and processes that are used to review for medical necessity and appropriateness of the requested items and services.
- Coordinating, directing, and monitoring the quality and cost effectiveness of utilization practice patterns of Providers to identify over and under service utilization.
- Ensuring that services are available in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness.
- Reviewing processes to ensure care is safe and accessible.
- Ensuring that qualified health care professionals perform all components of the UM/CM processes while providing timely responses to member appeals and grievances.
- Ensuring that UM decision tools are appropriately applied in determining medical necessity decisions.
- Identifying and assessing the need for Case Management through early identification of high or low service utilization and high cost chronic diseases.
- Promoting health care in accordance with local, State and national standards.
- Processing authorization requests timely and with adherence to all regulatory and accreditation timeliness standards.

Key Functions of the UM Program

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

- **Eligibility and Oversight**
  - Eligibility verification.
  - Benefit administration and interpretation.
  - Ensure authorized care correlates to member's medical necessity need(s) & benefit plan.
  - Verifying current Physician/hospital contract status.
  - Delegation oversight.
- **Resource Management**
  - Prior Authorization and referral management.
  - Pre-admission, Admission and Inpatient Review.
  - Post service/post claim audits.
  - 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 CMS, NCQA©, State and health plan UM standards.

This Molina Provider Manual contains excerpts from Molina's Healthcare Services Program Description. For a complete copy of South Carolina's Healthcare Services Program Description you can access the Molina website or contact the UM Department to receive a written copy. You can always find more information about Molina's UM program, including information about obtaining a copy of clinical criteria used for authorizations and how to contact an UM reviewer on Molina's website or by calling the UM department.

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

UM Decisions

A decision is any determination (e.g., an approval or denial) made by Molina or the delegated Medical Group/IPA or other delegated entity with respect to the following:

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

Molina follows a hierarchy of medical necessity decision making with Federal and State regulations taking precedence. Molina covers all services and items required by State and Federal regulations.

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

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

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

Medical Necessity

"Medically Necessary" or **"Medical Necessity"** means that the service is directed toward the maintenance, improvement, or protection of health, or toward the diagnosis and treatment of illness or disability (the provision of which may be limited by specific manual provisions, bulletins, and other directives). This is for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. Those services must be deemed by Molina to be:

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

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

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

Medical Necessity Review

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

Levels of Administrative and Clinical Review

The Molina review process begins with administrative review followed by clinical review if appropriate. The administrative review includes verifying eligibility, appropriate vendor or Participating Provider, and benefit coverage.

- Verifying member eligibility.
- Requested service is a covered benefit.
- Requested service is within the Provider's scope of practice.
- The requested covered service is directed to the most appropriate contracted specialist, facility or vendor.

The Clinical review includes medical necessity and level of care.

- Requested service is not experimental or investigation in nature;
- Servicing Provider can provide the service in a timely manner;
- The receiving specialist(s) and/or hospital is/are provided the required medical information to evaluate a member's condition;
- Medical necessity criteria (according to accepted, nationally-recognized resources) is met;
- The service is provided at the appropriate level of care in the appropriate facility; e.g., outpatient versus inpatient or at appropriate level of inpatient care;
- Continuity and coordination of care is maintained; and,
- The PCP is kept apprised of service requests and of the service provided to the member by other Providers.

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

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

Clinical Information

Molina requires copies of clinical information be submitted for documentation in all medical necessity determination processes. Clinical information includes but is not limited to; physician emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations and therapist notes. Molina does not accept clinical summaries, telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless State or Federal regulations allows such documentation to be acceptable.

Prior Authorization

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

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

- Member demographic information (name, date of birth, Molina ID number).
- Provider demographic information (referring Provider and referred to Provider/facility).
- Member diagnosis and ICD-10 codes.
- Requested service/procedure, including all appropriate CPT and HCPCS codes.
- Location where service will be performed.
- Clinical information sufficient to document the medical necessity of the requested services is required, including:
    - Pertinent medical history (include treatment, diagnostic tests, examination data).
    - Requested length of stay (for inpatient requests).
    - Rationale for expedited processing.

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State Law) are excluded from the prior authorization requirements. Prior Authorization is not a guarantee of payment. Payment is contingent upon medical necessity and member eligibility atfthe time o service.

Molina makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the member's clinical situation. The definition of expedited/urgent is when the situation where the standard time frame or decision-making process could seriously jeopardize the life or health of the enrollee or could jeopardize the enrollee's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

For expedited request for authorization, a determination is made as promptly as the member's health requires and no later than seventy-two (72) hours after we receive the initial request for service in the event a Provider indicates, or if we determine that a standard authorization decision time frame could jeopardize a member's life or health. For a standard authorization request, Molina makes the determination and provides notification within 2 (two) business days of the receipt of all necessary information.

Providers who request prior authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina has a full-time Medical Director available to discuss medical necessity decisions with the requesting Provider at (855) 237-6178.

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

Peer to Peer

Upon receipt of an adverse determination, the provider (peer) may request a peer to peer discussion within 3 days of the decision for prior authorization requests. For inpatient admissions, a request for a peer to peer discussion may be granted as long as the member is still in the facility.

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

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

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

Requesting Prior Authorization

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

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

Fax: The Prior Authorization Request Form can be faxed to Molina at: (866) 423-3889. To request imaging studies (CT/MRI/Ultrasound/Cardiac Imaging), please fax (877) 731-7218.

Phone: Prior authorizations can be initiated by contacting Molina's Healthcare Services Department at (855) 237-6178. It may be necessary to submit additional documentation before the authorization can be processed.

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

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

Emergency Services

Emergency Services means: health care services needed to evaluate, stabilize or treat an Emergency Medical Condition.

Emergency Medical Condition or Emergency means: Circumstances which a reasonably prudent person would regard as the unexpected onset of sudden or acute illness or injury requiring immediate medical care such that the member's life or health would have been jeopardized had the care been delayed.

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

Emergency Services are covered on a twenty-four (24) hour basis without the need for prior authorization for all members experiencing an Emergency Medical Condition.

Molina accomplishes this service by providing a twenty-four (24) hour Nurse Advise line for post business hours. In addition, the 911 information is given to all members at the onset of any call to the plan.

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

Member payments to the non-participating facility will not apply to the member's deductible or annual out-of-pocket maximum.

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

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

Inpatient Management

Elective Inpatient Admissions

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

Emergent Inpatient Admissions

Molina requires notification of all emergent inpatient admissions within twenty-four (24) hours of admission or by the following business day. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. Molina requires that notification includes member demographic information, facility information, date of admission and clinical information sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting notification, medical necessity requirements, or failure to include all of the needed clinical documentation to support the inpatient admission will result in a denial of authorization for the inpatient stay.

Inpatient at time of Termination of Coverage

If a member's coverage with Molina terminates during a hospital stay, all services received after their termination of eligibility are not covered services.

Inpatient/Concurrent Review

Molina performs concurrent inpatient review to ensure medical necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. Molina will request updated clinical records from inpatient facilities at regular intervals

during a member's inpatient stay. Molina requires that requested clinical information updates be received by Molina from the inpatient facility within twenty-four (24) hours of the request. Failure to provide timely clinical information updates may result in a denial of authorization for the remainder of the inpatient stay dependent on the Provider contract terms and agreements.

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

Inpatient Status Determinations

Molina's UM staff follow CMS guidelines to determine if the collected clinical information for requested services are "reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of malformed body member" by meeting all coverage, coding and medical necessity requirements (refer to the Medical Necessity Standards section of this manual).

Discharge Planning

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

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

Readmissions

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

When a subsequent admission to the same participating hospital or facility is identified within 30 calendar days from the date of discharge, Molina's Medical Director will conduct a review of both stays to determine if the subsequent admission is in fact a readmission. If it is determined that the subsequent admission is related to the first admission (readmission) and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

- A Readmission is considered potentially preventable if it is clinically related to the prior admission and includes the following circumstances:
    - Premature or inadequate discharge from the same hospital;
    - Issues with transition or coordination of care from the initial admission;
    - For an acute medical complication plausibly related to care that occurred during the initial admission.
- Readmissions that are excluded from consideration as preventable readmissions include:

- Planned readmissions associated with major or metastatic malignancies, multiple trauma, and burns.
- Certain chronic conditions for which subsequent Readmissions are often either not preventable or are expected to require significant follow-up care.
- Neonatal and obstetrical Readmissions.
- Initial admissions with a discharge status of "left against medical advice" because the intended care was not completed.
- Behavioral Health readmissions

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

Exceptions

1. The readmission is determined to be due to an unrelated condition from the first inpatient admission AND there is no evidence that premature or inadequate discharge, transition or coordination of care from the initial admission necessitated the second admission.
2. The readmission is part of a medically necessary prior authorized or staged treatment plan.
3. There is clear medical record documentation that the patient left the hospital AMA during the first hospitalization prior to completion of treatment and discharge planning.

Post Service Review

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

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

Affirmative Statement about Incentives

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

Molina affirms that all UM decision making is based solely on appropriateness of care and service and existence of coverage for its members, and not on the cost of the service to either Molina or the delegated group. Molina does not specifically reward Providers or other individuals for issuing denials of coverage or care.

Open Communication about Treatment

Molina prohibits contracted Providers from limiting Provider or member communication regarding a member's health care. Providers may freely communicate with, and act as an advocate for their patients. Molina requires provisions within Provider

contracts that prohibit solicitation of members for alternative coverage arrangements for the primary purpose of securing financial gain. No communication regarding treatment options may be represented or construed to expand or revise the scope of benefits under a health plan or insurance contract.

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

Delegated Utilization Management Functions

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

Communication and Availability to Members and Providers

During business hours HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff by calling (855) 237-6178 during normal business hours, Monday through Friday (except for Holidays) from 8:00 a.m. to 5:00 p.m. All staff members identify themselves by providing their first name, job title, and organization.

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

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

Molina's Nurse Advice Line is available to members and Providers twenty-four (24) hours a day, seven (7) days a week at (844) 800-5155. Molina's Nurse Advice Line handles urgent and emergent after-hours UM calls. PCPs are notified via fax of all Nurse Advice Line encounters.

Out of Network Providers and Services

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

Except for Emergency Services and out-of-area Urgent Care Services, Marketplace members must receive Covered Services from Participating Providers; otherwise, the services are not covered. Marketplace members will be one-hundred percent (100%) responsible for payment and the payments will not apply to towards Deductibles or Annual Out-of-Pocket Maximums.

Case Management

Coordination of Care and Services

Molina HCS Staff work with Providers to assist with coordinating referrals, services and benefits for members who have been identified for Molina's Integrated Case

Management (ICM) program via assessment, self-referral, Provider referral, etc. It is the responsibility of contracted Providers to assess members and with the participation of the member and/or their authorized representative(s), create an individualized care plan (ICP). The ICP is documented in the medical record and is updated as conditions, needs and/or health status change. In addition, the coordination of care process assists Molina members, as necessary, in transitioning to other care when benefits end. The process includes mechanisms for identifying Molina members whose benefits are ending and need continued care.

Molina staff assists Providers by identifying needs and issues that may not be verbalized by Providers, assisting to identify resources such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with Providers, members and/or their authorized representative(s) to ensure efforts are efficient and non-duplicative.

There are two (2) main coordination of care processes for Molina members. The first occurs when a new member enrolls in Molina and needs to transition current medical care to Molina contracted Providers. Mechanisms within the enrollment process identify the members and the member & Provider Contact Center (M&PCC) reach out to the members to assist in obtaining authorizations, transferring to contracted DME vendors, receiving approval for prescription medications, etc. The second coordination of care process occurs when a Molina member's benefits will be ending, and they need assistance in transitioning to other care. The process includes mechanisms for identifying Molina members whose benefits are ending and are in need of continued care.

Continuity of Care and Transition of Members

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

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

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

Reporting of Suspected Abuse and/or Neglect

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

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

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

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

Child Abuse and Adult Abuse

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

Mailing Address:
P.O. Box 1520
Columbia, SC 29202-1520

Website: https://dss.sc.gov/contact

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

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

Continuity and Coordination of Provider Communication

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

Case Management

Molina Case Management includes Health Management (HM) and Case Management (CM) programs. members may qualify for HM or CM based on confirmed diagnosis or specified criteria for the programs. These comprehensive programs are available for all members that meet the criteria for services.

PCP Responsibilities in Case Management Referrals

The member's PCP is the primary leader of the health team involved in the coordination and direction of services for the member. The case manager provides the PCP with reports, updates, and information regarding the member's progress through the Case Management plan. The PCP is responsible for the provision of preventive services and for the primary medical care of members.

Case Manager Responsibilities

The case manager collaborates with the member all resources involved in the member's care to develop an ICP that includes recommended interventions from the member's interdisciplinary care team (ICT). ICP interventions include links to the appropriate institutional and community resources, to address medical and psychosocial needs and/or barriers to accessing care, care coordination to address member's health care goals, health education to support self-management goals, and a statement of expected outcomes. Jointly, the case manager, Providers, and the member are responsible for implementing the plan of care. Additionally, the case manager:

- Monitors and communicates the progress of the implemented plan of care to all involved resources.
- Serves as a coordinator and resource to team members throughout the implementation of the plan and makes revisions to the plan as suggested and needed.
- Coordinates appropriate education and encourages the member's role in self-help.
- Monitors progress toward the member's achievement of treatment plan goals in order to determine an appropriate time for the member's discharge from the ICM program.

Health Management

Molina's Health Management programs can be incorporated into the member's treatment plan to address the member's health care needs. Primary prevention programs may include smoking cessation and weight management. There are also disease-specific health management programs for Asthma and Depression. Molina also offers a Maternity program to support healthy outcomes for pregnant member and their babies.

In addition to Asthma and Depression, other programs are offered such as:

- Weight Management – For information about the telephonic Molina Weight Management Program or to enroll members, please contact our member Assessment Unit.
- Smoking Cessation – For information about the Molina Smoking Cessation Program or to enroll members, please contact our Health Management Unit.
- Maternity Program – For information about Maternity Program or to enroll members, please contact our OB Prenatal service Unit.

Pregnancy Notification Process

The PCP shall submit to Molina the Pregnancy Notification Report Form (available at www.MolinaHealthcare.com) within one (1) working day of the first prenatal visit and/or positive pregnancy test. The form should be faxed to Molina at (866) 423-3889.

Case Management (CM)

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

The Molina case managers may be licensed professionals and are educated, trained and experienced in the Care Management process. The ICM program is based on a member advocacy philosophy, designed and administered to assure the member value- added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes. The ICM program is individualized to accommodate a member's needs with collaboration and approval from the member's PCP. The Molina case manager will arrange individual services for members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina case manager is responsible for assessing the member's appropriateness for the ICM program and for notifying the PCP of the evaluation results, as well as making a recommendation for a treatment plan.

Referral to Care Management: members with high-risk medical conditions and/or other care needs may be referred by their PCP or specialty care Provider to the ICM program. The case manager works collaboratively with all members of the integrated care team (ICT), including the PCP, hospital UM staff, discharge planners, specialist Providers, ancillary Providers, the local Health Department and other community resources. The referral source provides the case manager with demographic, health care and social data about the member being referred.

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

- High-risk pregnancy, including members with a history of a previous preterm delivery
- Preterm infants
- Catastrophic medical conditions (e.g., neoplasm, organ/tissue transplants)
- Chronic illness (e.g., asthma, diabetes, End Stage Renal Disease)
- High-technology home care requiring more than two (2) weeks of treatment
- Member accessing Emergency Department services inappropriately

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

Phone : (855) 237-6178
Fax : (843) 740-1773

8. QUALITY

Maintaining Quality Improvement Processes and Programs

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

The address for mail requests is:

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

This Provider Manual contains excerpts from the Molina Quality Improvement Program. For a complete copy of Molina's Quality Improvement Program, you can contact your Provider Services Representative or call the telephone number above to receive a written copy.

Molina has established a Quality Improvement Program that complies with regulatory and accreditation guidelines. The Quality Improvement Program provides structure and outlines specific activities designed to improve the care, service and health of our members.

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

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

Patient Safety Program

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

Quality of Care

Molina has an established and systematic process to identify, investigate, review and report any Quality of Care, Adverse Event/Never Event, Critical Incident (as applicable), and/or service issues affecting member care. Molina will research,

resolve, track and trend issues. Confirmed Adverse Events/Never Events are reportable when related to an error in medical care that is clearly identifiable, preventable and/or found to have caused serious injury or death to a patient. Some examples of never events include:

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

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

Medical Records

Molina requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to members is consistently documented, and that necessary information is readily available in the medical record. All entries will be indelibly added to the member's record. PCPs should maintain the following components:

- Medical record confidentiality and release of medical records are maintained including behavioral health care records;
- Medical record content and documentation standards are followed, including preventive health care;
- Storage maintenance and disposal processes are maintained; and,
- Process for archiving medical records and implementing improvement activities is outlined.

Medical Record Keeping Practices

Below is a list of the minimum items that are necessary in the maintenance of the member's Medical records:

- Each patient has a separate record.
- Medical records are stored away from patient areas and preferably locked.
- Medical records are available at each visit and archived records are available within twenty-four (24) hours.
- If hardcopy, pages are securely attached in the medical record and records are organized by dividers or color-coded when thickness of the record dictates.
- If electronic, all those with access have individual passwords.
- Record keeping is monitored for Quality and HIPAA compliance.
- Storage maintenance for the determined timeline and disposal per record management processes.
- Process for archiving medical records and implementing improvement activities.
- Medical records are kept confidential and there is a process for release of medical records including behavioral health care records.

Content

Providers must remain consistent in their practices with Molina's medical record documentation guidelines. Medical records are maintained and should include the following information:

- Member name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact;
- Legible signatures and credentials of Provider and other staff members within a paper chart;
- All Providers who participate in the member's care;
- Information about services delivered by these Providers;
- A problem list that describes the member's medical and behavioral health conditions;
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers;
- Prescribed medications, including dosages and dates of initial or refill prescriptions;
- Allergies and adverse reactions (or notation that none are known);
- Documentation that Advanced Directives, Power of Attorney and Living Will have been discussed with member, and a copy of Advance Directives when in place;
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors;
- Treatment plans that are consistent with diagnosis;
- A working diagnosis that is recorded with the clinical findings;
- Pertinent history for the presenting problem;
- Pertinent physical exam for the presenting problem;
- Lab and other diagnostic tests that are ordered as appropriate by the practitioner;
- Clear and thorough progress notes that state the intent for all ordered services and treatments;
- Notations regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed, included in the next preventative care visit when appropriate;
- Notes from consultants if applicable;
- Up-to-date immunization records and documentation of appropriate history;
- All staff and Provider notes are signed physically or electronically with either name or initials;
- All entries are dated;
- All abnormal lab/imaging results show explicit follow up plan(s);
- All ancillary services reports;
- Documentation of all emergency care provided in any setting;
- Documentation of all hospital admissions, inpatient and outpatient, including the hospital discharge summaries, hospital history and physicals and operative report;
- Labor and Delivery Record for any child seen since birth; and,
- A signed document stating with whom protected health information may be shared.

Organization

- The medical record is legible to someone other than the writer.
- Each patient has an individual record.
- Chart pages are bound, clipped, or attached to the file.

- Chart sections are easily recognized for retrieval of information.
- A release document for each member authorizing Molina to release medical information for facilitation of medical care.

Retrieval

- The medical record is available to Provider at each Encounter.
- The medical record is available to Molina for purposes of quality improvement.
- The medical record is available to South Carolina Department of Health and Human Services (SCDHHS) and the External Quality Review Organization upon request.
- The medical record is available to the member upon their request.
- A storage system for inactive member medical records which allows retrieval within twenty-four (24) hours, is consistent with State and Federal requirements, and the record is maintained for not less than ten (10) years from the last date of treatment or for a minor, one (1) year past their 20th birthday but, never less than 10 (ten) years.
- An established and functional data recovery procedure in the event of data loss.

Confidentiality

Molina Providers shall develop and implement confidentiality procedures to guard member protected health information, in accordance with HIPAA privacy standards and all other applicable Federal and State regulations. This should include, and is not limited to, the following:

- Ensure that medical information is released only in accordance with applicable Federal or State Law in pursuant to court orders or subpoenas.
- Maintain records and information in an accurate and timely manner.
- Ensure timely access by members to the records and information that pertain to them.
- Abide by all Federal and State Laws regarding confidentiality and disclosure of medical records or other health an enrollment information.
- Medical Records are protected from unauthorized access.
- Access to computerized confidential information is restricted.
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
- Education and training for all staff on handling and maintaining protected health care information.

Additional information on medical records is available from your local Molina Quality Department toll free at (855) 237-6178. See also the Compliance Section of this Provider Manual for additional information regarding HIPAA.

Access to Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care (including behavioral health care) provided by contracted PCPs (adult and pediatric) and participating specialist (to include OB/GYN, behavioral health Providers, and high volume and high impact specialists). Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The

standards are based on ninety percent (90%) availability for Emergency Services and ninety percent (90%) or greater for all other services. The PCP or their designee must be available twenty-four (24) hours a day, seven (7) days a week to members.

Appointment Access

All Providers who oversee the member's health care are responsible for providing the following appointments to Molina members in the timeframes noted:

Medical Appointment

Appointment Types	Standard
Routine, asymptomatic	Within 4 weeks
Routine, symptomatic	Within 4 weeks
Urgent Care	Within forty-eight (48) hours
After Hours Care	24 hours/day; 7 day/week availability
Specialty Care (High Volume)	Within 12 weeks
Specialty Care (High Impact)	Within 12 weeks
Urgent Specialty Care	Within forty-eight (48) hours

Behavioral Health Appointment

Appointment Types	Standard
Life Threatening Emergency	Immediately
Non-life-Threatening Emergency	Within six (6) hours
Urgent Care	Within forty-eight (48) hours
Routine Care	Within 10 calendar days
Follow-up Routine Care	Within 10 calendar days

Additional information on appointment access standards is available from your local Molina Quality Department toll free at (855) 237-6178.

Office Wait Time

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

After Hours

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a twenty-four (24) hour telephone service, seven (7) days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct members with an Emergency to hang-up and call 911 or go immediately to the nearest emergency room.

Appointment Scheduling

Each Provider must implement an appointment scheduling system. The following are the minimum standards:

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments;
2. A process for documenting missed appointments must be established. When a member does not keep a scheduled appointment, it is to be noted in the member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the member must be documented in the medical record. If a second appointment is missed, the Provider is to notify the Molina Provider Services Department toll free at (855) 237-6178 or TTY/TDD 711;
3. When the Provider must cancel a scheduled appointment, the member is given the option of seeing an associate or having the next available appointment time;
4. Special needs of members must be accommodated when scheduling appointments. This includes, but is not limited to wheelchair-using members and members requiring language interpretation;
5. A process for member notification of preventive care appointments must be established. This includes, but is not limited to immunizations and mammograms; and,
6. A process must be established for member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

In applying the standards listed above, participating Providers have agreed that they will not discriminate against any member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, gender identity, pregnancy, sex stereotyping, place of residence, socioeconomic status, or status as a recipient of Medicaid benefits. Additionally, a participating Provider or contracted medical group/IPA may not limit their practice because of a member's medical (physical or mental) condition or the expectation for the need of frequent or high cost care. If a PCP chooses to close their panel to new members, Molina must receive thirty (30) days advance written notice from the Provider.

Women's Health Access

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

Additional information on access to care is available from your local Molina Quality department toll free at (855) 237-6178.

Monitoring Access forpClioamnce with Standards

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

1. Provider network adherence to access standards is monitored via the following mechanisms:
2. Provider access studies – Provider office assessment of appointment availability, and after-hours access.
3. Member complaint data – assessment of member complaints related to access to care.
4. Member satisfaction survey – evaluation of members' self-reported satisfaction with appointment and after-hours access.

Analysis of access data includes assessment of performance against established standards, review of trends over time, and identification of barriers. Results of analysis are reported to the Quality Improvement Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified Provider-specific or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement Committee.

Additional information on access to care is available under the Resources tab on the www.MolinaHealthcare.com website or is available from your local Molina Quality department toll free at (855) 237-6178.

Quality of Provider Office Sites

Molina Providers are to maintain office-site and medical record keeping practices standards. Molina continually monitors member complaints and appeals/grievances for all office sites to determine the need of an office site visit and will conduct office site visits as needed. Molina assesses the quality, safety and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This includes an assessment of:

- Physical Accessibility
- Physical Appearance
- Adequacy of Waiting and Examining Room Space

Physical Accessibility

Molina evaluates office sites to ensure that members have safe and appropriate access to the office site. This includes, but is not limited to, ease of entry into the building, accessibility of space within the office site, and ease of access for patients with physical disabilities.

Physical Appearance

The site visits include, but is not limited to, an evaluation of office site cleanliness, appropriateness of lighting, and patient safety.

Adequacy of Waiting and Examining Room Space

During the site visit, Molina assesses waiting and examining room spaces to ensure that the office offers appropriate accommodations to members. The evaluation includes, but is not limited to, appropriate seating in the waiting room areas and availability of exam tables in exam rooms.

Administration & Confidentiality of Facilities

Facilities contracted with Molina must demonstrate an overall compliance with the guidelines listed below:

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted, and parking area and walkways demonstrate appropriate maintenance.
- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two office exam rooms per Provider.
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one CPR certified employee is available.
- Yearly OSHA training (Fire, Safety, Blood-borne Pathogens, etc.) is documented for offices with ten (10) or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, and contracts evidence hazardous waste management.
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A CLIA waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double-locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

Advance Directives (Patient Self-Determination Act)

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

Advance Directives are a written choice for health care. There are three (3) types of Advance Directives:

- **Durable Power of Attorney for Health Care:** allows an agent to be appointed to carry out health care decisions
- **Living Will:** allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration
- **Guardian Appointment:** allows one to nominate someone to be appointed as Guardian if a court determines that a guardian is necessary.

When There Is No Advance Directive: The member's family and Provider will work together to decide on the best care for the member based on information they may know about the member's end-of-life plans.

Providers must inform adult Molina members, eighteen (18) years old and up, of their right to make health care decisions and execute Advance Directives. It is important that members are informed about Advance Directives.

New adult members or their identified personal representative will receive educational information and instructions on how to access advance directives forms in their Member Handbook, Evidence of Coverage (EOC) and other member communications such as newsletters and the Molina website. If a member is incapacitated at the time of enrollment, Molina will provide advance directive information to the member's family or representative and will follow up with information to the member at the appropriate time. All current members will receive annual notice explaining this information, in addition to newsletter information.

Members who would like more information are instructed to contact Member Services or are directed to the Caring Connections website at http://www.caringinfo.org/stateaddownload for forms available to download. Additionally, the Molina website offers information to both Providers and members regarding advance directives, with a link to forms that can be downloaded and printed.

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

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

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

Molina will notify the Provider of an individual member's Advance Directives identified through Case Management, Care Coordination or Case Management. Providers are instructed to document the presence of an Advance Directive in a prominent location of the Medical Record. Auditors will also look for copies of the Advance Directive form.

Advance Directives forms are State specific to meet State regulations.

Molina will look for documented evidence of the discussion between the Provider and the member during routine Medical Record reviews.

Services to Enrollees Under Twenty-One (21) Years of Age

Molina maintains monitoring-mechanisms to ensure all EPSDT services to enrollees under twenty-one (21) years of age are timely according to required preventive health guidelines. All enrollees under twenty-one (21) years of age should receive screening examinations including appropriate childhood immunizations at intervals as specified by the by the preventive health guidelines located on the Molina Website (www.MolinaHealthcare.com) and referenced in the Benefits and Covered Services section of this Provider Manual.

Well Child/Adolescent Visits

Visits consist of age appropriate components including but not limited to:

- Comprehensive health and developmental history.
- Nutritional assessment.
- Height and weight and growth charting.
- Comprehensive unclothed physical examination.
- Appropriate immunizations.
- Laboratory procedures, including lead blood level assessment appropriate for age and risk factors.
- Periodic developmental and behavioral screening.
- Vision and hearing tests.
- Dental assessment and services.
- Health education (anticipatory guidance including child development, healthy lifestyles. accident and disease prevention).

Diagnostic services, treatment, or services medically necessary to correct or ameliorate defects, physical or mental illnesses, and conditions discovered during a screening or testing must be provided or arranged for either directly or through referrals. Any condition discovered during the screening examination or screening test requiring further diagnostic study or treatment must be provided if within the member's Covered Benefit Services. Members should be referred to an appropriate source of care for any required services that are not Covered Services..

Molina shall have no obligation to pay for services that are not Covered Services.

Quality Improvement Activities and Programs

Molina maintains an active Quality Improvement Program. The Quality Improvement Program provides structure and key processes to carry out our ongoing commitment to improvement of care and service. The goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Health Management

The Molina Health Management Program provides for the identification, assessment, stratification, and implementation of appropriate interventions for members with chronic diseases. For additional information, please see the Health Management heading in the Healthcare Services section of this Provider Manual.

Case Management

Molina's Case Management Program involves collaborative processes aimed at meeting an individual's health needs, promoting quality of life, and obtaining best possible care outcomes to meet the member's needs so they receive the right care, at the right time, and at the right setting. Molina Case Management includes Health Management (HM) and Case Management (CM) programs. Members may qualify for HM or CM based on confirmed diagnosis or specified criteria for the programs. These comprehensive programs are available for all members that meet the criteria for services. For additional information please see the Case Management heading in the Healthcare Services section of this Provider Manual.

Clinical Practice Guidelines

Molina adopts and disseminates Clinical Practice Guidelines (CPGs) to Providers. All guidelines are based on scientific evidence, review of medical literature and/or appropriately established authority. CPGs are reviewed every two years and are updated as new recommendations are published.

Molina CPGs include the following:

- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure
- Hypertension
- Obesity
- Detoxification and Substance Abuse
- Opioid
- Sickle Cell Disease

The guidelines are disseminated through Provider newsletters, electronic Provider bulletins and other media and are available on the Molina website. Individual Providers or members may request copies from the local Molina Quality department toll free at (855) 237-6178.

Preventive Health Guidelines

Molina provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF) and in accordance with Centers for Medicare and Medicaid Services (CMS) guidelines.

Diagnostic preventive procedures include but are not limited to:

- Perinatal/Prenatal Care
- Care for children up to twenty-four (24) months old

- Care for children two to nineteen (2-19) years old
- Care for adults twenty to sixty-four (20-64) years old
- Care for adults sixty-five (65) years and older
- Immunization schedules for children and adolescents
- Immunization schedules for adults

All guidelines are updated with each release by USPSTF and are approved by the Quality Improvement Committee. On an annual basis, Preventive Health Guidelines are distributed to Providers at www.MolinaHealthcare.com and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Cultural and Linguistic Services

Molina works to ensure all members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. For additional information about Molina's program and services, please see the Cultural Competency and Linguistic Services section of this Provider Manual.

Measurement of Clinical and Service Quality

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

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Qualified Health Plan (QHP) Enrollee Experience Survey
- Behavioral Health Survey
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Initiatives
- Quality Rating System

Molina evaluates continuous performance according to, or in comparison with objectives, measurable performance standards and benchmarks at the national, regional and/or at the local/health plan level.

Contracted Providers and Facilities must allow Molina to use its performance data collected in accordance with the Provider's or facility's contract. The use of performance data may include, but is not limited to, the following: (1) development of Quality Improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced member cost sharing.

Molina's most recent results can be obtained from your local Molina Quality staff toll free at (855) 237-6178 or by visiting our website at www.MolinaHealthcare.com.

Healthcare Effectiveness Data and Information Set (HEDIS®)

Molina utilizes the NCQA© HEDIS© as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS© is an annual activity conducted in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently

includes a variety of health care aspects including immunizations, women's health screening, diabetes care, well check-ups, medication use, and cardiovascular disease.

HEDIS© results are used in a variety of ways. They are the measurement standard for many of Molina's clinical quality activities and health improvement programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the success of these programs.

Selected HEDIS© results are provided to regulatory and accreditation agencies as part of our contracts with these agencies. The data are also used to compare to established health plan performance benchmarks.

Qualified Health Plan (QHP) Enrollee Experience Survey

The QHP Enrollee Experience Survey is a consumer experience survey that assesses enrollee experience with QHPs offered through Marketplaces. The QHP Enrollee Survey is fielded nationally by HHS-approved survey vendors using a standardized protocol to facilitate QHP comparison both within and across Marketplaces.

The QHP Enrollee Experience Survey was designed to collect accurate and reliable information from consumers about their experience with the health care they received through Health Insurance Marketplace Qualified Health Plans (QHPs). The survey includes a set of core questions that address key areas of care and service, with some questions grouped to form composites.

QHP Enrollee Survey topics include:

- Access to care
- Access to information
- Care coordination
- Cost
- Cultural competence
- Customer Service
- Doctor's communication
- Health promotion
- Plan administration
- Prevention
- Shared decision-making
- Specialized services

Behavioral Health Survey

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

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey both focus on member experience with health care Providers and health plans, Molina conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina, as this is one of the primary methods used to identify improvement areas pertaining to the Molina Provider Network. The survey results have helped establish improvement activities relating to Molina's specialty network, inter- Provider communications, and pharmacy authorizations. This survey is fielded to a random sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of Quality Improvement Initiatives

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

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

Quality Rating System

Based on Section 1311(c)(3) of the Affordable Care Act, CMS developed the Quality Rating System (QRS) to:

- Provide comparable and useful information to consumers about the quality of health care services provided by QHPs;
- Facilitate oversight of QHP issuer compliance with Marketplace quality standards; and,
- Provide actionable information for improving quality and performance.

Quality ratings are calculated for each eligible QHP product using clinical quality and enrollee experience survey data. Based on results, CMS will calculate and produce quality performance ratings for each health plan on a 1 to 5-star rating scale.

Measures are organized into a hierarchical structure designed to make the QRS scores and ratings more understandable. They include, but are not limited, to the following domains:

- Clinical Effectiveness
- Patient Safety
- Prevention
- Access
- Doctor and Care
- Efficiency and Affordability
- Plan Service

What Can Providers Do?

- Ensure patients are up-to-date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology;
- Review the HEDIS® preventive care listing of measures for each patient to determine if anything applicable to your patients' age and/or condition has been missed;
- Check that staff is properly coding all services provided; and,
- Be sure patients understand what they need to do.

Molina has additional resources to assist Providers and their patients. For access to tools that can assist, please visit Molina's website and click on Providers. There is a variety of resources, including:

- HEDIS® CPT/CMS-approved diagnostic and procedural code sheets
- A current list of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey Star Ratings measures.

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

9. COMPLIANCE

Fraud, Waste, and Abuse

Introduction

Molina's Compliance program monitors compliance with federal and state laws, including health care fraud, waste and abuse statutes and regulations. Molina is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Molina's Compliance department maintains a comprehensive plan, which is designed to address how will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. The plan also addresses education of appropriate employees, vendors, providers and associates doing business with Molina Healthcare.

A Special Investigations Unit (SIU) is a key element of the program. Molina's Special Investigation Unit (SIU) supports Compliance in its efforts to deter and prevent fraud, waste, and abuse by conducting investigations aimed at identifying suspect activity and report findings to the appropriate regulatory and/or law enforcement agencies.

Mission Statement

Molina regards health care fraud, waste, and abuse as unacceptable, unlawful, and harmful to the provision of quality health care in an efficient and affordable manner. Molina has therefore implemented a plan to detect, prevent, investigate, and report suspected health care fraud, waste, and abuse in order to reduce health care cost and to promote quality health care.

Regulatory Requirements

Federal False Claims Act

The False Claims Act is a Federal statute that covers fraud involving any Federally funded contract or program. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

The term "knowing" is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or, Acts in reckless disregard of the truth or falsity of the information in a claim.

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care Providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

Deficit Reduction Act

The Deficit Reduction Act ("DRA") aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

Health care entities like Molina who receive or pay out at least $5 million dollars in Medicaid funds per year must comply with the DRA. As a contractor doing business with Molina, Providers and their staff have the same obligation to report any actual or suspected violation of Medicare/Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and State Laws pertaining to submitting false Claims;
- How Providers will detect and prevent fraud, waste, and abuse;
- Employee protection rights as whistleblowers.

The Federal False Claims Act and State Medicaid False Claims Act have Qui Tam language commonly referred to as "whistleblower" provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims Act. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in disclosing or reporting a false Claim are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority.
- Two times the amount of back pay plus interest.
- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions.

Affected entities who fail to comply with the Law will be at risk of forfeiting all Medicaid payments until compliance is met. Molina will take steps to monitor Molina contracted Providers to ensure compliance with the Law.

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

Stark Statute – Similar to the Anti-Kickback Statute, but more narrowly defined and applied. It applies specifically to Medicare and Medicaid services provided only by physicians, rather than by all health care Providers.

Sarbanes-Oxley Act of 2002 – Requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Definitions

Fraud: means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State Law. (42 CFR § 455.2)

Waste: means Health care spending that can be eliminated without reducing the quality of care. Quality waste includes, overuse, underuse, and ineffective use. Inefficiency waste includes redundancy, delays, and unnecessary process complexity.

An example would be the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome resulted in poor or inefficient billing methods (e.g. coding) causing unnecessary costs.

Abuse: means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary (42 CFR § 455.2) costs and services.

Clean Claim: A clean claim is one that is accurate, complete (that is, includes all information necessary to determine Molina Healthcare Inc liability), not a claim on appeal, and not contested (that is, not reasonably believed to be fraudulent and not subject to a necessary release, consent or assignment).

Examples of Fraud, Waste and Abuse by a Provider

The types of questionable Provider schemes investigated by Molina include, but are not limited to the following:

- A Provider knowingly and willfully referring Molina members to health care facilities in which or with which the Provider has a financial relationship. (Stark Law)
- Altering Claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a member for covered services. For example, asking the member to pay the difference between the discounted fees, negotiated fees, and the Provider's usual and customary fees.
- Billing and providing for services to members that are not medically necessary.
- Billing for services, procedures and/or supplies that have not been rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.
- Completing certificates of Medical Necessity for members not personally and professionally known by the Provider.
- Concealing a member's misuse of a Molina identification card.
- Failing to report a member's forgery or alteration of a prescription or other medical document.
- False coding in order to receive or maximize reimbursement.
- Inappropriate billing of modifiers in order to receive or maximize reimbursement.
- Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement.
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients.
- Not following incident to billing guidelines in order to receive or maximize reimbursement.
- Overutilization
- Participating in schemes that involve collusion between a Provider and a member that result in higher costs or charges.
- Questionable prescribing practices.
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are Medically Necessary.

- Upcoding, which is when a Provider does not bill the correct code for the service rendered, and instead uses a code for a like services that costs more.
- Using the adjustment payment process to generate fraudulent payments.

Examples of Fraud, Waste, and Abuse by a Member

The types of questionable member schemes investigated by Molina include, but are not limited to, the following:

- Benefit sharing with persons not entitled to the member's benefits.
- Conspiracy to defraud Medicaid.
- Doctor shopping, which occurs when a member consults a number of Providers for the purpose of inappropriately obtaining services.
- Falsifying documentation in order to get services approved.
- Forgery related to health care.
- Prescription diversion, which occurs when a member obtains a prescription from a Provider for a condition that they do not suffer from and the member sells the medication to someone else.

Review of Provider Claims and Claims System

Molina Claims Examiners are trained to recognize unusual billing practices and to detect fraud, waste and abuse. If the Claims Examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the Compliance Department.

The claims payment system utilizes system edits and flags to validate those elements of claims are billed in accordance with standardized billing practices; ensure that claims are processed accurately and ensure that payments reflect the service performed as authorized.

Molina performs auditing to ensure the accuracy of data input into the claims system. The Claims department conducts regular audits to identify system issues or errors. If errors are identified, they are corrected, and a thorough review of system edits is conducted to detect and locate the source of the errors.

Prepayment Fraud, Waste, and Abuse Detection Activities

Through implementation of claims edits, Molina's claims payment system is designed to audit claims concurrently, in order to detect and prevent paying claims that are inappropriate.

Molina has a pre-payment Claims auditing process that identifies frequent correct coding billing errors ensuring that Claims are coded appropriately according to State and Federal coding guidelines. Code edit relationships and edits are based on guidelines from specific State Medicaid Guidelines, Centers for Medicare and Medicaid Services (CMS), Federal CMS guidelines, AMA and published specialty specific coding rules. Code Edit Rules are based on information received from the National Physician Fee Schedule Relative File (NPFS), the Medical Medically Unlikely Edit table, the Medicaid National Correct Coding Initiative (NCCI) files and State-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

Additionally, Molina may, at the request of a State program or at its own discretion, subject a Provider to prepayment reviews whereupon Provider is required to submit supporting source documents that justify an amount charged. Where no supporting documents are provided, or insufficient information is provided to substantiate a charge, the claim will be denied until such time that the Provider can provide sufficient accurate support.

Post-payment Recovery Activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement, and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to Molina under the Provider Agreement or at Law or equity.

In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement, the parties agree that Molina shall in its sole discretion exercise the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under Law and equity, or some combination thereof.

Provider will provide Molina, governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Molina, in Molina's sole discretion, necessary to determine compliance with the terms of the Provider Agreement, including for the purpose of investigating potential fraud, waste and abuse. Documents and records must be readily accessible at the location where Provider provides services to any Molina members. Auditable documents and records include, but are not limited to, medical charts; patient charts; billing records; and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by Molina and without charge to Molina. In the event Molina identifies fraud, waste or abuse, Provider agrees to repay funds or Molina may seek recoupment.

If a Molina auditor is denied access to Provider's records, all of the claims for which Provider received payment from Molina is immediately due and owing. If Provider fails to provide all requested documentation for any claim, the entire amount of the paid Claim is immediately due and owing. Molina may offset such amounts against any amounts owed by Molina to Provider. Provider must comply with all requests for documentation and records timely (as reasonably requested by Molina) and without charge to Molina. Claims for which Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 154.501). Provider further acknowledges that in order to receive payment from Molina, Provider is required to allow Molina to conduct audits of its pertinent records to verify the services performed and the payment claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy Laws.

Claim Auditing

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

Provider acknowledges Molina's right to conduct pre and post-payment billing audits. Provider shall cooperate with Molina's Special Investigations Unit and audits of claims and payments by providing access at reasonable times to requested claims information, all supporting medical records, Provider's charging policies, and other related data as deemed relevant to

support the transactions billed. Providers are required to submit, or provide access to, medical records upon Molina's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

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

Provider audits may be telephonic, an on-site visit, internal claims review, client- directed/regulatory investigation and/or compliance reviews and may be vendor assisted. Molina asks that you provide Molina, or Molina's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

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

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

Medical Records

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

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

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

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

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

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

Provider Appeal Procedures

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

- The written letter of appeal must be clearly labeled "Appeal Regarding SIU Audit Results;"
- A copy of the issued audit findings letter must be attached to the written letter of appeal;

The written letter of appeal must contain all necessary information, such as the original claim(s), medical record(s), prior authorization letter(s) or form(s), and any **new** information pertinent to the appeal, which **was not** originally submitted and/or reviewed by the SIU during the audit process.

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

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

Provider Education

When Molina identifies through an audit or other means a situation with a Provider (e.g. coding, billing) that is either inappropriate or deficient, Molina may determine that a Provider education visit is appropriate.

Molina will notify the Provider of the deficiency and will take steps to educate the Provider, which may include the Provider submitting a corrective action plan (CAP) to Molina addressing the issues identified and how it will cure these issues moving forward.

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina AlertLine. AlertLine is an external telephone and web-based reporting system hosted by NAVEX Global, a leading Provider of compliance and ethics hotline services. AlertLine telephone and web-based reporting is available twenty-four (24) hours a day, seven (7) days a week, three-hundred-sixty-five (365) days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina Compliance department for follow-up. If you elect to use the web- based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

Molina AlertLine can be reached toll free at (866) 606-3889 or you may use the service's website to make a report at any time at https://MolinaHealthcare.alertline.com

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

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

Remember to include the following information when reporting:

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

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

Office of South Carolina Attorney General
Toll Free Phone: (888) 953-7283

HIPAA Requirements and Information

HIPAA (The Health Insurance Portability and Accountability Act) Molina's Commitment to Patient Privacy

Protecting the privacy of members' personal health information is a core responsibility that Molina takes very seriously. Molina is committed to complying with all Federal and State Laws regarding the privacy and security of members' protected health information (PHI).

Provider Responsibilities

Molina expects that its contracted Provider will respect the privacy of Molina members (including Molina members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and member PHI. Molina provides its members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Molina uses and discloses their PHI and includes a summary of how Molina safeguards their PHI.

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

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

Applicable Laws

Providers must understand all State and Federal health care privacy Laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead

there is a patchwork of Laws that Providers must comply with. In general, most health care Providers are subject to various Laws and regulations pertaining to privacy of health information, including, without limitation, the following:

1. Federal Laws and Regulations
    - HIPAA
    - The Health Information Technology for Economic and Clinical Health Act (HITECH)
    - 42 C.F.R. Part 2
    - Medicare and Medicaid Laws
    - The Affordable Care Act
2. State Medical Privacy Laws and Regulations.

    Providers should be aware that HIPAA provides a floor for patient privacy, but that State Laws should be followed in certain situations, especially if the State Law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

Uses and Disclosure of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable Law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[1]. Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services[2].
2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:
    - Quality improvement;
    - Disease management;
    - Case management and care coordination;
    - Training Programs;
    - Accreditation, licensing, and credentialing

Importantly, this allows Providers to share PHI with Molina for our health care operations activities, such as HEDIS® and Quality Improvement.

[1] See, Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule
[2] See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

Confidentiality of Substance Use Disorder Patient Records

Federal Confidentiality of Substance Use Disorder Patients Records regulations apply to any entity or individual providing Federally-assisted alcohol or drug abuse prevention treatment. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with substance use disorder treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, the Federal Confidentiality of Substance Use Disorder Patients Records regulations are more restrictive than HIPAA and they do not allow disclosure without the member's written consent except as set forth in 42 CFR Part 2.

Inadvertent Disclosures of PHI

Molina may, on occasion, inadvertently misdirect or disclose PHI pertaining to Molina member (s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected Molina members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI and further agrees to provide an attestation of return, destruction and non-disclosure of any such misdirected PHI upon the reasonable request of Molina.

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable Law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable State Law. A sample Authorization for the Use and Disclosure of Protected Health Information is included at the end of this section.

Patient Rights

Patients are afforded various rights under HIPAA. Molina Providers must allow patients to exercise any of the below-listed rights that apply to the Provider's practice:

1. Notice of Privacy Practices
Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.

2. Requests for Restrictions on Uses and Disclosures of PHI
Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.

3. Requests for Confidential Communications
Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.

4. Requests for Patient Access to PHI
Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the member's care or payment for care.

5. Request to Amend PHI
Patients have a right to request that the Provider amend information in their designated record set.

6.Request Accounting of PHI Disclosures
Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations or made prior to April 14, 2003.

HIPAA Security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of Molina member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cyber security measures. Providers should recognize that identity theft – both financial and medical -- is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

Medical identity theft is an emerging threat in the health care industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity –such as health insurance information—without the person's knowledge or consent to obtain health care services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Molina.

HIPAA Transactions and Code Sets

Molina requires the use of electronic transactions to streamline health care administrative activities. Molina Providers must submit Claims and other transactions to Molina using electronic formats. Certain electronic transactions in health care are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

- Claims and Encounters
- Member eligibility status inquiries and responses
- Claims status inquiries and responses
- Authorization requests and responses
- Remittance advices

Molina is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to Molina's website at www.MolinaHealthcare.com for additional information regarding HIPAA standard transactions.

1. Click on the area titled "I'm a Health Care Professional"
2. Click the tab titled "HIPAA"
3. Click on the tab titled "HIPAA Transactions" or "HIPAA Code Sets"

Code Sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions. For Claims with dates of service prior to October 1, 2015, ICD-9 coding must be used. For Claims with dates of service on or after October 1, 2015, Providers must use the ICD-10 code sets.

National Provider Identifier

Provider must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Molina and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within thirty (30) days and should also be reported to Molina within thirty (30) days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all Claims and Encounters submitted to Molina.

Additional Requirements for Delegated Providers

Providers that are delegated for Claims and Utilization Management activities are the "business associates" of Molina. Under HIPAA, Molina must obtain contractual assurances from all business associates that they will safeguard member PHI. Delegated Providers must agree to various contractual provisions required under HIPAA's Privacy and Security Rules.

Reimbursement for Copies of PHI

Molina does not reimburse Providers for copies of PHI related to our members. These requests may include, although are not limited to, the following purposes:

- Utilization Management
- Care Coordination and/or Complex Medical Case Management Services
- Claims Review
- Resolution of an Appeal and/Grievance
- Anti-Fraud Program Review
- Quality of Care Issues
- Regulatory Audits
- Risk Adjustment
- Treatment, Payment and/or Operation Purposes
- Collection of HEDIS® medical records

Nonpublic Information Cybersecurity Attachment

1. Note: This section is only applicable to Providers who are a delegated Provider and delegated a health plan function. Provider shall comply with the following requirements and permit Molina to audit such compliance as required by law or any regulatory agency.
2. Provider shall implement appropriate administrative, technical, and physical measures to protect and secure the Information Systems and Nonpublic Information that are accessible to, or held by, the Provider.
3. Definitions:
    i. "Cybersecurity Event" means an event resulting in unauthorized access to or the disruption or misuse of an Information System or information stored on an Information System. The term "Cybersecurity Event" does not include the unauthorized acquisition of encrypted Nonpublic Information if the encryption, process or

key is not also acquired, released or used without authorization. The term "Cybersecurity Event" also does not include an event with regard to which Provider has determined that the Nonpublic Information accessed by an unauthorized person has not been used or released and has been returned or destroyed.

ii. "Information Systems" means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination or disposition of electronic information, as well as any specialized system such as industrial or process controls systems, telephone switching and private branch exchange systems, and environmental control systems.

iii. "Nonpublic Information" means information that is not publicly available information and is:

a. business related information of Molina the tampering with which, or unauthorized disclosure, access, or use of which, would cause a material adverse impact to the business, operations, or security of Molina;

b. any information concerning a consumer which because of name, number, personal mark, or other identifier can be used to identify such consumer, in combination with any one or more of the following data elements:

i. social security number;

ii. driver's license number or nondriver identification card number;

iii. account number, credit or debit card number;

iv. security code, access code, or password that would permit access to a consumer's financial account; or

v. biometric records;

C. any information or data, except age or gender, in any form or medium created by or derived from a health care Provider or a consumer and that relates to:

i. the past, present, or future physical, mental or behavioral health or condition of a consumer or a member of the consumer's family;

ii. the provision of health care to a consumer; or

iii. payment for the provision of health care to a consumer.

4. Molina agrees to comply with all applicable laws governing Cybersecurity Events, including notification requirements. Molina will decide on further action including, but not limited to, notification to affected individuals or government entities. Upon Molina's prior written request, Provider agrees to assume responsibility for informing all such individuals in accordance with applicable law.

5. In the event of a Cybersecurity Event, Provider shall notify Molina's Chief Information Security Officer of such Cybersecurity Event by telephone and email as provided below (with follow-up notification by mail) as promptly as possible, but in no event later than seventy-two (72) hours from a determination that a Cybersecurity Event has occurred.

Notification to Molina's Chief Information Security Officer shall be provided to: Molina
Chief Information Security Officer
Telephone: (844) 821-1942
Email: CyberIncidentReporting@MolinaHealthcare.com
Molina Chief Information Security Officer

Molina Healthcare, Inc.
200 Oceangate Blvd., Suite 100
Long Beach, CA 90802

6. Further, in the event of a Cybersecurity Event, Provider must provide Molina any documentation required by Molina to complete an investigation, or, upon written request by Molina, complete an investigation pursuant to the following requirements:

    a. determine whether a Cybersecurity Event occurred;
    b. assess the nature and scope of the Cybersecurity Event;
    c. identify Nonpublic Information that may have been involved in the Cybersecurity Event; and
    d. perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release, or use of Nonpublic Information in Molina or Provider's possession, custody, or control.

7. Provider shall maintain records concerning all Cybersecurity Events for a period of at least five (5) years from the date of the Cybersecurity Event or such longer period as required by applicable laws and produce those records upon demand of Molina.

8. Provider must provide Molina the required information in electronic form as directed by Molina. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Molina concerning the Cybersecurity Event. The information provided to Molina must include at least the following:

    a. the date of the Cybersecurity Event;
    b. a description of how the information was exposed, lost, stolen, or breached, including the specific roles and responsibilities of Provider, if any;
    c. how the Cybersecurity Event was discovered;
    d. whether any lost, stolen, or breached information has been recovered and if so, how this was done;
    e. the identity of the source of the Cybersecurity Event;
    f. whether Provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and, if so, when such notification was provided;
    g. a description of the specific types of information acquired without authorization, which means particular data elements including, for example, types of medical information, types of financial information, or types of information allowing identification of the consumer;
    h. the period during which the Information System was compromised by the Cybersecurity Event;
    i. the number of total consumers in the State affected by the Cybersecurity Event;

j. the results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;

k. a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;

l. a copy of Provider's privacy policy and a statement outlining the steps Provider will take to investigate and if requested by Molina, the steps that Provider will take to notify consumers affected by the Cybersecurity Event; and

m. the name of a contact person who is both familiar with the Cybersecurity Event and authorized to act on behalf of Provider.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member Name:_____ Member ID #:_____
Member Address:_____ Date of Birth:_____
City/State/Zip:_____ Telephone #:_____

I hereby authorize the use or disclosure of my protected health information as described below.

1. Name of persons/organizations authorized to make the requested use or disclosure of protected health information:

_____
_____
_____

2. Name of persons/organizations authorized to receive the protected health information:

_____
_____
_____

3. Specific description of protected health information that may be used/disclosed:

_____
_____
_____

4. The protected health information will be used/disclosed for the following purpose(s):

_____
_____
_____

5. The person/organization authorized to use/disclose the protected health information will receive compensation for doing so. Yes____ No____
6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 7 and 8 on this form.
7. Molina may condition the provision of research related treatment on my provision of an authorization for the use or disclosure of PHI for such research.

8. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Molina reserves the right to deny that health care.
9. I understand that I have a right to receive a copy of this authorization, if requested by me.
10. I understand that I may revoke this authorization at any time by notifying Molina in writing, except to the extent that:
    a. action has been taken in reliance on this authorization; or,
    b. if this authorization is obtained as a condition of obtaining health care coverage, other Law provides the Health Plan with the right to contest a Claim under the benefits or coverage under the plan.
11. I understand that the information I authorize a person or entity to receive may be no longer protected by Federal Law and regulations.
12. This authorization expires on the following date or event*:

    _____

    **If no expiration date or event is specified above, this authorization will expire 12 months from the date signed below*.

Signature of Member or Member's Personal Representative	Date
Printed Name of Member or Member's Personal Representative, if applicable	Relationship to Member or Personal Representative's Authority to act for the Member applicable

A copy of this signed form will be provided to the Member, if the authorization was sought by Molina.

10. CLAIMS AND COMPENSATION

As a contracted Provider, it is important to understand how the Claims process works to avoid delays in processing your Claims. The following items are covered in this section for your reference:

- Hospital Acquired Conditions and Present on Admission Program
- Claim Submission
- Coordination of Benefits (COB)/Third Party Liability (TPL)
- Timely Claim Filing
- Claim Edit Process
- Claim Review
- Claim Auditing
- Corrected Claims
- Timely Claim Processing
- Electronic Claim Payment
- Overpayment and Incorrect Payment
- Claims Disputes/Reconsiderations
- Billing the member
- Fraud and Abuse
- Encounter Data

Hospital-Acquired Conditions and Present on Admission Program

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

The following is a list of CMS Hospital Acquired Conditions. Effective October 1, 2008, CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission (POA):

1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers
5. Falls and Trauma
    a) Fractures
    b) Dislocations
    c) Intracranial Injuries

d) Crushing Injuries
e) Burn
f) Other Injuries

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

What this means to Providers

- Acute IPPS Hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing; and
- No additional payment will be made on IPPS hospital claims for conditions that are acquired during the patient's hospitalization.

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

Claim Submission

Participating Providers are required to submit Claims to Molina with appropriate documentation. Providers must follow the appropriate State and CMS Provider billing guidelines. Providers must utilize electronic billing though a clearinghouse or Molina's Provider Portal whenever possible and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID number 46299. For members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim Submission instructions on the member's Molina ID card.

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

Required Elements

The following information must be included on every claim:

- Member name, date of birth and Molina member ID number.
- Member's gender.
- Member's address.
- Date(s) of service.
- Valid International Classification of Diseases diagnosis and procedure codes.
- Valid revenue, CPT or HCPCS for services or items provided.
- Valid Diagnosis Pointers.
- Total billed charges.
- Place and type of service code.
- Days or units as applicable.
- Provider tax identification number (TIN).
- 10-digit National Provider Identifier (NPI).
- Rendering Provider name as applicable.
- Billing/Pay-to Provider name and billing address.
- Place of service and type (for facilities).
- Disclosure of any other health benefit plans.
- E-signature.
- Service Facility Location information.

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

National Provider Identifier (NPI)

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

Electronic Claims Submission

Molina requires Participating Providers to submit Claims electronically, including secondary claims. Electronic Claims submission provides significant benefits to the Provider including:

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

Molina offers the following electronic Claims submission options:

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

Provider Portal

Molina's Provider Portal offers a number of claims processing functionalities and benefits:

- Available to all Providers at no cost
- Available twenty-four (24) hours per day, seven (7) days per week
- Ability to add attachments to claims (Provider Portal and clearinghouse submissions)
- Ability to submit corrected claims
- Easily and quickly void claims
- Check claims status
- Receive timely notification of a change in status for a particular claim

Clearinghouse

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

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

When your Claims are filed via a Clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse
- You should also receive 277CA response file with initial status of the claims from your clearinghouse
- You should contact your local clearinghouse representative if you experience any problems with your transmission

EDI Claims Submission Issues

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

Paper Claim Submissions

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

Molina Healthcare of South Carolina, Inc.
PO Box 22664
Long Beach, CA 90801

Please keep the following in mind when submitting paper claims:

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

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

For members enrolled in a Molina Marketplace plan, Molina and/or contracted Medical Groups/IPAs are financially responsible for the care provided to these members. Molina Marketplace will pay Claims for Covered Services, however if COB/TPL is determined post payment, Molina Marketplace will attempt to recover any Overpayments.

Timely Claim Filing

Provider shall promptly submit to Molina Claims for Covered Services rendered to members. All Claims shall be submitted in a form acceptable to and approved by Molina and shall include all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by Provider to Molina within three-hundred-sixty-five (365) calendar days after the discharge for inpatient services or the Date of Service for outpatient services. If Molina is not the primary payer under coordination of benefits or third-party liability, Provider must submit Claims to Molina within three-hundred-sixty-five (365) calendar days after final determination by the primary payer. Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Reimbursement Guidance and Payment Guidelines

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

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

- Manuals and Relative Value Unit (RVU) files published by the Centers for Medicare and Medicaid Services (CMS), including:
    - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUEs). In the event a State benefit limit is more stringent/restrictive than a Federal MUE, Molina will apply the State benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a Federal MUE or State benefit limit the professional organization standard may be used.
    - In the absence of State guidance, Medicare National Coverage Determinations (NCDs).
    - In the absence of State guidance, Medicare Local Coverage Determinations (LCDs).
    - CMS Physician Fee Schedule RVU indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than State and Federal guidelines.
- Molina policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Molina.

General Coding Requirements

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

CPT and HCPCS Codes

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

Modifiers

Modifiers consist of two (2) alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers may be appended only if the clinical circumstances justify the use of the modifier(s). For example, modifiers may be used to indicate whether a:

- Service or procedure has a professional component
- Service or procedure has a technical component

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

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

ICD-10-CM/PCS Codes

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

Place of Service (POS) Codes

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

Type of Bill

Type of bill is a four-digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC's) Official UB- 04 Data Specifications Manual.

Revenue Codes

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

Diagnosis Related Group (DRG)

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

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

Coding Sources

Definitions

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

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

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

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

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

Molina will not separately reimburse a clinic fee or any other facility fee associated with space used to provide E&M services in the event they are billed on a UB-04 claim or successor form ('facility fee') regardless if the office is located on the hospital campus and/or uses the hospital tax identification number for the Marketplace product.

The following are the conditions under which such claims will be denied:

- Type of Bill: 13X
- Revenue Code: 51X
- E&M Procedure Codes: 99201-99205, 99211-99215, or G0463

Claim Auditing

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

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

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

Provider audits may be telephonic, an on-site visit, internal claims review, client- directed/regulatory investigation and/or compliance reviews and may be vendor assisted. Molina asks that you provide us, or our designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

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

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

Corrected Claims

Corrected Claims are considered new Claims for processing purposes. Corrected Claims must be submitted electronically with the appropriate fields on the 837I or 837P completed. Molina's Provider Portal includes functionality to submit corrected Institutional and Professional claims. Corrected claims must include the correct coding to denote if the claim is Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P and include the original claim number. Claims submitted without the correct coding will be returned to the Provider for resubmission.

EDI (Clearinghouse) Submission

837P

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

837I

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

Timely Claim Processing

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will process the claim for service within the timeframe required by Law after receipt of Clean Claims, which is forty (40) business days for paper claims and twenty (20) business days for electronic claims. The receipt date of a Claim is the date Molina receives notice of the Claim.

Electronic Claim Payment

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

Overpayments and Incorrect Payments Refund Requests

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

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

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

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

Claim Disputes/Reconsiderations

Providers disputing a Claim previously adjudicated must request such action within ninety (90) days of Molina's original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.); all Claim disputes must be submitted on the Molina Claims Request for Reconsideration Form (CRRF) found on Provider website and the Provider Portal. The form must be filled out completely in order to be processed.

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

Providers should submit the following documentation:

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

Forms may be submitted via fax, secure email or mail. Claims Disputes/Reconsideration requested via the CRRF may be sent to the following address:

Molina Healthcare of South Carolina, Inc.
Attention: Claims Disputes/Adjustments
PO Box 40309
North Charleston, SC 29423-0309

Submitted via fax: (877) 901-8182

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

The Provider will be notified of Molina's decision in writing within ninety (90) days of receipt of the Claims Dispute/Adjustment request.

Billing the Member

- Providers contracted with Molina cannot bill the member for any covered benefits, beyond applicable co-payments, deductibles or co-insurance. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.
- Providers agree that under no circumstance shall a member be liable to the Provider for any sums owed by Molina to the Provider
- Provider agrees to accept payment from Molina as payment in full, or bill the appropriate responsible party
- Provider may not bill a Molina member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:
    - The member has been advised by the Provider that the service is not a covered benefit and the Provider has documentation.
    - The member has been advised by the Provider that they are not contracted with Molina and has documentation.
    - The member agrees in writing to have the service provided with full knowledge that they are financially responsible for payment.

Fraud and Abuse

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

Encounter Data

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

Encounters must be submitted every sixty (60) days and within three-hundred-sixty-five (365 days) from the date of service. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D -- Dental. Data must be submitted with Claims level detail for all non-institutional services provided.

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

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

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

When Encounters are filed electronically Providers should receive two (2) types of responses:

- First, Molina will provide a 999 acknowledgement of the transmission.
- Second, Molina will provide a 277CA response file for each transaction.

11. COMPLAINTS, GRIEVANCE AND APPEALS PROCESS

Molina members or member's authorized representatives have the right to file a grievance and submit an appeal through a formal process. All grievances and appeals must be submitted to Molina for resolution.

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

Complaints

A complaint is any dissatisfaction with Molina or any Participating Provider that is not related to the denial of health care services. For example, a member may be dissatisfied with the hours of availability of their doctor. Issues relating to the denial of health care services are Appeals and should be filed with Molina in the manner described in the Internal Appeals section below.

For member complaints, call the following toll-free number for assistance:

- Molina at (855) 885-3176, Monday through Friday, 8:00 a.m. - 6:00 p.m. ET.
- Deaf or hard of hearing, contact Molina by dialing 711 for the TTY Relay Service.

Members can also write to Molina at:
Molina Healthcare of South Carolina, Inc.
Attn: Member Appeals and Grievances
PO Box 40309
North Charleston, SC 29423

Additional information can be found Molina's website at www.MolinaMarketplace.com

Members may also contact the South Carolina Department of Insurance at:
Consumer Services Division
P.O. Box 100105
Columbia, SC 29202-3105
Phone : (803) 737-6180 or (800) 768-3467
Fax : (803) 737-6231
E-mail : consumers@doi.sc.gov
Online complaint form: https://online.doi.sc.gov/Eng/Public/Consumer/Complaint.aspx

Molina recognizes the fact that members may not always be satisfied with the care and services provided by our contracted doctors, hospitals and other providers. Molina will respond to the complaint no later than ninety (90) days from when the complaint is received. This period may be extended if there is a delay in obtaining the documents or records that are necessary to resolve the complaint or if the member and Molina agree in writing to extend the period.

Pending the resolution of the complaint, Molina will not terminate the member's coverage for any reason which is the subject of the complaint, except that Molina does have the right to terminate the member's coverage where Molina has made a good faith, reasonable effort to resolve the complaint and termination is otherwise permitted.

Internal Appeals and External Review

Definitions

Adverse Benefit Determination – means a decision by Molina:

1. To deny, reduce, fail to provide, or terminate a requested health care service or payment in whole or in part, due to any of the following:
    a. A determination that the health care service does not meet Molina's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, including Experimental or Investigational treatments;
    b. A determination that a health care service is not a Covered Service;
    c. The imposition of an exclusion source of injury, network, or any other limitation on benefits that would otherwise be covered.
2. Not to issue individual health insurance coverage to an applicant, including initial eligibility determinations;
3. To rescind coverage on a health benefit plan.

Final Adverse Benefit Determination – means an Adverse Benefit Determination that is upheld after the internal appeal process.

Urgent Care Service – means a medical service where the application of non-Urgent Care Service time frames:

- Could seriously jeopardize the member's life, health, ability to regain maximum function, or the member's unborn child; or,
- In the opinion of the treating physician, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Appointing a Representative

If the member would like someone to act on the member's behalf regarding a claim or an appeal of an Adverse Benefit Determination the member may appoint an authorized representative or Molina participating provider. Please send the member's representative's name, address, and telephone contact information to:

Molina Healthcare of South Carolina, Inc.
Attn: Member Appeals and Grievances
PO Box 40309
North Charleston, SC 29423

Tel : (855) 885-3176 or 711 (TTY)
Fax : (866) 713-1891
Email : SCMIRR@MolinaHealthcare.com

The member must pay the cost of anyone the member hires to represent or help the member.

A provider can appeal on a Molina member's behalf if the member has agreed to treatment; Molina has received medical records from the provider; and/or there is a history of paid claims for services from the provider.

Throughout this "Internal Appeals and External Review" section, any reference to the term "member" and "member's" may include the person or entity who initiated the request (including the member's authorized representative).

Initial Denial Notices

Notice of an Adverse Benefit Determination will be provided to the member orally, by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted below.

An Adverse Benefit Determination notice will identify the claim or authorization request involved, convey the specific reason for the Adverse Benefit Determination (including the denial code and its meaning), the specific product provisions upon which Molina bases the determination, and the contact information for the South Carolina Department of Insurance, which is available to assist the member with the internal and external appeal processes. The notice will also include a description of any additional information necessary to perfect the claim or request, and an explanation of why such information is necessary. The notice will disclose if any internal product rule, protocol, or similar criterion was relied upon to deny the claim or request. Upon request, a copy of the rule, protocol, or similar criterion will be provided to the member, free of charge. In addition to the information provided in the notice, the member has the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

The notice will describe Molina's internal and external (standard and expedited) appeal procedures, the time limits applicable to such procedures following an Adverse Benefit Determination on review and include the release form authorizing Molina to disclose protected health information pertinent to an external review. It will also include a description of the circumstances under which the member does not have to exhaust (complete) the internal process or the internal process may be deemed exhausted.

If an Adverse Benefit Determination is based on Medical Necessity, Experimental or Investigational treatment or similar exclusion or limitation, then upon request, Molina will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of the product to the member's medical circumstances.

In the case of an Adverse Benefit Determination involving an Urgent Care Service, the notice will provide a description of Molina's expedited review procedures, which Molina describes below.

Internal Appeals

The member must appeal an Adverse Benefit Determination within one-hundred-eighty (180) days after receiving written notice of the denial (or partial denial). The member may appeal an Adverse Benefit Determination by means of written notice to Molina, in person, orally, or by mail, postage prepaid.

The request should include:

- The date of the request.
- The member's name (please print or type).
- The date of the service Molina denied.
- The member's identification number claim or request number, and Provider name as shown on the explanation of health care benefits, which the member will automatically receive when Molina processes the member's claim or request.

The member should keep a copy of the request for their records because no part of it can be returned to the member.

The member may request an expedited internal appeal of an Adverse Benefit Determination involving an Urgent Care Service orally or in writing. In such case, all necessary information will be transmitted between Molina and the member by telephone, FAX, or other available similarly expeditious method, to the extent permitted by applicable law.

Determination of appeals of Adverse Benefit Determinations will be conducted promptly, will not defer to the initial determination, and will not be made by the person who made the initial Adverse Benefit Determination or a subordinate of that person. The member also has the right to request that the person performing the review must be in the same or similar specialty as the attending health care Provider. The determination will take into account all comments, documents, records, and other information submitted by the member relating to the claim or request.

On appeal, the member may review relevant documents, request copies of any relevant information (which will be provided free of charge) and may submit issues and comments in writing. Upon request, the member may also discover the identity of medical or vocational experts whose advice was obtained on behalf of Molina in connection with the Adverse Benefit Determination being appealed, as permitted under applicable law.

If Molina bases the Adverse Benefit Determination in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, drug, or other service is Experimental or Investigational, or not Medically Necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

If new or additional evidence is relied upon or if new or additional rationale is used during the internal appeal process, Molina will provide to the member, free of charge, the evidence or rationale as soon as possible and in advance of the appeals decision in order to provide the member a reasonable opportunity to respond. However, if Molina receives the new or additional evidence so late that it would be impossible to provide it to the member in time for the member to have a reasonable opportunity to respond, the period for providing notice of Molina's appeal decision will be tolled until the member has a reasonable opportunity to respond. After the member responds or has a reasonable opportunity to respond but fails to do so, Molina will notify the member of Molina's decision as soon as reasonably possible, considering the medical circumstances.

The member's coverage will remain in effect pending the outcome of the member's internal appeal.

Time Periods for Decisions on Appeal

For appeals of Adverse Benefit Determinations, Molina will make decisions and provide notice of the decisions as follows:

Time Frame for Responding to Appeal

Request Type	Time Frame for Decision
Pre-service Appeals	Molina will notify the member in writing of Molina's appeal decision as soon as practical, taking into account the medical circumstances, but not later than thirty (30) calendar days after Molina's receipt of the member's appeal.

Request Type	Time Frame for Decision
Post-service Appeals	Molina will notify the member in writing of Molina's appeal decision as soon as practical, which generally will not be later than thirty (30) calendar days after Molina's receipt of all information necessary to complete the appeal. However, in extraordinary circumstances, Molina will have up to sixty (60) calendar days from the date that the member submits an appeal to provide the member with notification of Molina's appeal decision.
Expedited Appeals (Urgent Care Service Decisions)	Molina will give the member oral notice of Molina's appeal decision as soon as possible, considering the medical circumstances, but not later than either of the following timeframes: • Two (2) business days of Molina's receipt of all information necessary to complete the appeal. • Seventy-two (72) hours from Molina's receipt of the member's appeal

Appeals Denial Notices

Notice of a Final Adverse Benefit Determination (including a partial denial) will be provided to the member by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time periods noted above.

A Final Adverse Benefit Determination will include:

- Sufficient information to identify the claim or request involved.
- The specific reason or reasons for the Final Adverse Benefit Determination, including the denial code and its meaning.
- Reference to the specific product provision upon which the determination is based;
- A statement that the member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the member's claim or request for benefits.
- If Molina relied upon any internal Molina rule, protocol or similar criterion to deny the claim or request, then a copy of the rule, protocol or similar criterion will be provided to the member, free of charge, along with a discussion of Molina's decision.
- A statement of the member's right to external review, a description of the standard and expedited external review process, and the forms for submitting an external review request, including release forms authorizing Molina to disclose protected health information pertinent to the external review.
- If Molina bases a Final Adverse Benefit Determination on Medical Necessity, Experimental or Investigational treatment or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of this Agreement to the member's medical circumstances.
- Notice of voluntary alternative dispute resolution options, as applicable.
- The contact information for the director of the South Carolina Department of Insurance, which is available to assist with the internal and external appeal processes.

In addition to the information provided in the notice, the member has the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

Exhaustion of the Internal Claims and Appeals Processes

A request for standard or expedited external review can't be made until the member has exhausted (completed) Molina's internal claims and appeals processes and received a Final

Adverse Benefit Determination. However, in the following circumstances, the member can request external review prior to exhausting Molina's internal processes:

- Waiver: Except in regard to post-service appeals, Molina can waive the exhaustion requirement, in which case the member can request external review without exhausting Molina's internal processes.
- Simultaneous Requests for Expedited Internal and External Reviews: The member may also request an expedited external review of an Adverse Benefit Determination involving an Urgent Care Service at the same time a request is made for an expedited internal appeal of an Adverse Benefit Determination if the member's treating physician certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize the member's life or health, or would jeopardize the member's ability to regain maximum function, if treated after the time frame of an expedited internal appeal (i.e., seventy-two (72)-hours). The member may not file a request for expedited external review unless the member also files an expedited internal appeal.
- Deemed Exhaustion:

  If Molina do not adhere to the requirements outlined above, the internal claims and appeals processes may be deemed exhausted and the member may have the right to request external review or other remedies under State Law. If the internal processes are deemed exhausted, this is considered a Final Adverse Benefit Determination.

  In order for the internal processes to be deemed exhausted, the member needs to request a written explanation from Molina and Molina will respond in writing within ten (10) calendar days. The external reviewer or court will review Molina's explanation along with the member's request and make a determination of whether the internal processes are exhausted. If the member's request is rejected, Molina will notify the member within ten (10) calendar days. The member will have the right to resubmit and pursue an internal appeal of the Adverse Benefit Determination. Time periods for refiling will begin to run upon the member's receipt of that notice.

External Review

Understanding the External Review Process

After the member receives a Final Adverse Benefit Determination or if the member is otherwise permitted, as described above, the member may request an external review if the member believes that a health care service has been improperly denied, modified, or delayed on the grounds that the health care service does not meet Molina's requirements for Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or is Experimental or Investigational.

An external review will be conducted by an Independent Review Organization (IRO). Molina will not choose or influence the IRO's reviewers.

There are three (3) types of IRO reviews: 1) standard external review, 2) expedited external review, and 3) external review of Experimental or Investigational treatment.

Standard External Review

The IRO will provide the member and Molina with written notice of its decision within forty-five (45) calendar days of its receipt of the member's request for standard external review.

Expedited External Review

An expedited review for urgent medical situations, including reviews of Experimental or Investigational treatment involving an urgent medical situation are normally completed within seventy-two (72) hours and can be requested if any of the following applies:

- The member's treating physician certifies that the Adverse Benefit Determination or Final Adverse Benefit Determination involves a medical condition that could seriously jeopardize the member's life or health or would jeopardize the member's ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal or a standard external review,
- The Adverse Benefit Determination or Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care service for which the member received emergency services, but have not yet been discharged from a facility.

External Review of Experimental and Investigational Treatment

Requests for standard or expedited external reviews that involve Adverse Benefit Determinations or Final Adverse Benefit Determinations that a treatment is Experimental or Investigational may proceed if the member's treating physician, who must be a licensed physician qualified to practice in the area of medicine appropriate to treat the member's condition, certifies:

- The member has a life-threatening disease or seriously disabling condition; and,
- Medical and scientific evidence, using accepted protocols, shows that the requested health care service is more beneficial to the member than any standard health care service covered by Molina, and the adverse risks of the requested health care service are not substantially greater than the standard health care service that is covered by Molina; and,
- One of the following:
    - Standard health care services have not been effective in improving the member's condition;
    - Standard health care services are not medically appropriate for the member; or,
    - No available standard health care service covered by Molina is more beneficial than the requested health care service.

Request for External Review in General

- The member must request a standard external review within 120 days of the date of the notice of Adverse Benefit Determination or Final Adverse Benefit Determination issued by Molina. A request for an expedited external review has no filing deadline.

- All requests must be in writing.
- Molina will initiate the external review by notifying the South Carolina Department of Insurance of the member's request, which will assign the IRO to conduct the external review. For standard external review requests, Molina will notify the member in writing of the assignment to an IRO.
    - The notice will include the name and contact information for the assigned IRO for the purpose of submitting additional information.
    - The notice will inform the member that, within five (5) business days after receipt of the notice, the member may submit additional information in writing to the IRO for consideration in the review
- Molina will also forward all documents and information used to make the Adverse Benefit Determination or Final Adverse Benefit Determination to the assigned IRO.
- If Molina determines that the Adverse Benefit Determination is not eligible for external review, Molina will notify the member in writing within five (5) business days of Molina's receipt of the member's request for standard external review. For expedited requests, Molina will notify the member as quickly as reasonably possible. The notice will provide the member with the reason for the denial, notify the member of the director's availability to provide assistance, and provide his phone number and address.
- Molina will pay the costs of the external review.

IRO Assignment

When Molina initiates an external review, the South Carolina Department of Insurance will utilize an impartial and independent rotational system to assign the review to a South Carolina accredited IRO that is qualified to conduct the review based on the type of health care service. Molina will verify that no conflict of interest exists with the IRO.

IRO Review and Decision

- Within five (5) business days after the IRO's receipt of the member's request for standard external review, the IRO will determine whether the member's request is eligible for external review and confirm that all information, forms and certifications were provided. The IRO will notify the member immediately if additional information is required. If the member's request is not accepted for standard external review, the IRO will provide the member and Molina with written notice explaining the reason. The IRO will notify the member and Molina if the member's request is accepted for standard external review. This paragraph does not apply to expedited external reviews.
- If the IRO is reviewing an Adverse Benefit Determination or Final Adverse Benefit Determination involving an Experimental or Investigational treatment, the IRO will
- immediately select a clinical peer review panel to conduct the external review upon accepting the member's request. The panel will be chosen by the IRO and will include experts on the treatment of the member's condition and the requested health care service. Molina has the right to request that this panel include at least three (3) health care professionals who meet these requirements. Each member of the panel will provide the IRO with a written opinion of whether to uphold or reverse the member's Adverse Benefit Determination or Final Adverse Benefit Determination.
- The external review decision will be based on the recommendation of the majority of the clinical peer reviewers.
- The IRO must forward, upon receipt, any additional information it receives from the member to Molina. At any

time, Molina may reconsider its Adverse Benefit Determination or Final Adverse Benefit Determination and provide coverage for the health care service. Reconsideration will not delay or terminate the external review. If Molina reverses the Adverse Benefit Determination or Final Adverse Benefit Determination, Molina will notify the member and the assigned IRO of that decision within five (5) days for a standard review, and as quickly as reasonably possible for an expedited review. Upon receipt of the notice of reversal by Molina, the IRO will terminate the review.

- In addition to all documents and information considered by Molina in making the Adverse Benefit Determination, the IRO must consider things such as: the member's medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under this Agreement, the most appropriate practice guidelines, clinical review criteria developed by Molina, and any additional information or documents that were submitted by the member. If the review is involving an Experimental or Investigational treatment, the IRO will consider whether the requested health care service is approved by the Federal Food and Drug Administration, or whether medical and scientific evidence demonstrate that the expected benefits of the requested health care service are greater than the benefits covered by Molina and the adverse risks of the requested health care service are not substantially greater than Molina's covered services.
- The IRO will provide the member and Molina with written notice of its decision within forty-five (45) calendar days of its receipt of the member's request for a standard review. The IRO will provide the member and Molina with notice of an expedited review decision within seventy-two (72) hours of receipt by Molina of a request for an expedited review. If the expedited review decision is not in writing, written notice will be provided within forty-eight (48) hours of providing the oral notice. The written notice will include the following information:
    - A general description of the reason for the request for external review.
    - The date the independent review organization was assigned by the South Carolina Department of Insurance to conduct the external review.
    - The dates over which the external review was conducted.
    - The date on which the independent review organization's decision was made.
    - The principal reason for its decision.
    - The rationale for its decision.
    - References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision.
    - The written opinions of the clinical peer review panel, if any.
- If the IRO reverses the Adverse Benefit Determination or Final Adverse Benefit Determination, Molina will approve a covered benefit that was the subject of a standard request within five (5) business days of Molina's receipt of the notice from the IRO, and as quickly as reasonable possible for an expedited request, subject to applicable exclusions, limitations, or other provisions.

Binding Nature of External Review Decision

- An external review decision is binding on Molina except to the extent Molina has other remedies available under State Law. The decision is also binding on the member except to the extent that the member has other remedies available under applicable State or Federal Law.

- The member may not file a subsequent request for an external review involving the same Adverse Benefit Determination that was previously reviewed.

If the member has Questions About their Rights or Need Assistance with the Internal Claims and Appeals or External Review Processes, the member may contact:

South Carolina Department of Insurance
Consumer Services Division
P.O. Box 100105
Columbia, SC 29202-3105

Phone : 1 (803) 737-6180 or 1 (800) 768-3467
Fax : 803-737-6231
E-mail : consumers@doi.sc.gov
Online complaint form: https://online.doi.sc.gov/Eng/Public/Consumer/Complaint.aspx

Reporting

All Grievance/Appeal data, including Provider specific data, is reported quarterly to member /Provider Satisfaction Committee by the Department Managers for review and recommendation. A Summary of the results is reported to the Executive Quality Improvement Committee (EQIC) quarterly. Annually, a quantitative/qualitative report will be compiled and presented to the member /Provider Satisfaction Committee (MPSC) and EQIC by the chairman of MPSC to be included in the organization's Grand Analysis of customer satisfaction and assess opportunities for improvement.

Record Retention

Molina will maintain all grievance and related appeal documentation on file for a minimum of ten (10) years. In addition to the information documented electronically via Call Tracking in QNXT or maintained in other electronic files, Molina will retain copies of any written documentation submitted by the Provider pertaining to the grievance/appeal process. Provider shall maintain records for a period not less than ten (10) years from the termination of the Model Contract and retained further if the records are under review or audit until the review or audit is complete. (Provider shall request and obtain Health Plan's prior approval for the disposition of records if Agreement is continuous.)

12. CREDENTIALING AND RECREDENTIALING

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

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

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

Non-Discriminatory Credentialing and Recredentialing

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

Types of Practitioners Credentialed & Recredentialed

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

Practitioner types requiring credentialing include but are not limited to:

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

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

Credentialing Turn-Around Time

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

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

Criteria for Participation in the Molina Network

Molina has established criteria and the sources used to verify these criteria for the evaluation and selection of practitioners for participation in the Molina network. These criteria have been designed to assess a practitioner's ability to deliver care. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Molina network. To remain eligible for participation, practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina.

Molina reserves the right to exercise discretion in applying any criteria and to exclude practitioners who do not meet the criteria. Molina may, after considering the recommendations of the Professional Review Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined such waiver is necessary to meet the needs of Molina and the community it serves. The refusal of Molina to waive any requirement shall not entitle any practitioner to a hearing or any other rights of review.

Practitioners must meet the following criteria to be eligible to participate in the Molina network. The practitioner shall have the burden of producing adequate information to prove they meets all criteria for initial participation and continued

participation in the Molina network. If the practitioner fails provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or administrative termination from the Molina network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

- **Application –** Provider must submit to Molina a complete credentialing application either from CAQH ProView or other State mandated practitioner application. The attestation must be signed within one-hundred-twenty (120) days. Application must include all required attachments.
- **License, Certification or Registration –** Provider must hold a current and valid license, certification or registration to practice in their specialty in every State in which they will provide care and/or render services for Molina members. Telemedicine practitioners are required to be licensed in the state where they are located and the State the member is located.
- **DEA or CDS Certificate –** Provider must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Provider must have a DEA or CDS in every State where the Provider provides care to Molina members. If a practitioner has never had any disciplinary action taken related to their DEA and/or CDS and has a pending DEA/CDS certificate or chooses not to have a DEA and/or CDS certificate, the practitioner must then provide a documented process that allows another practitioner with a valid DEA and/or CDS certificate to write all prescriptions requiring a DEA number. If a practitioner does not have a DEA or CDS because it has been revoked, restricted or relinquished due to disciplinary reasons, the practitioner is not eligible to participate in the Molina network.
- **Specialty –** Providers must only be credentialed in the specialty in which they have adequate education and training. Providers must confine their practice to their credentialed area of practice when providing services to Molina members.
- **Education –** Practitioner must have graduated from an accredited school with a degree required to practice in their designated specialty.
- **Residency Training –** Practitioners must have satisfactorily completed residency programs from accredited training programs in the specialties in which they are practicing. Molina only recognizes residency training programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, podiatric residencies are required to be three (3) years in length. If the podiatrist has not completed a three (3)-year residency or is not board certified, the podiatrist must have five (5) years of work history practicing podiatry.
- **Fellowship Training –** If the Practitioner is not board certified in the specialty in which they practice and has not completed a residency program in the specialty in which they practice, they must have completed a fellowship program from an accredited training program in the specialty in which they are practicing.
- **Board Certification –** Board certification in the specialty in which the practitioner is practicing is not required. Initial applicants who are not board certified will be considered for participation if they have satisfactorily completed

a residency program from an accredited training program in the specialty in which they are practicing. Molina recognizes board certification only from the following Boards:

- American Board of Medical Specialties (ABMS)
- American Osteopathic Association (AOA)
- American Board of Foot and Ankle Surgery (ABFAS)
- American Board of Podiatric Medicine (ABPM)
- American Board of Oral and Maxillofacial Surgery
- American Board of Addiction Medicine (ABAM)
- College of Family Physicians of Canada (CFPC)
- Royal College of Physicians and Surgeons of Canada (RCPSC)
- Behavioral Analyst Certification Board (BACB)
- National Commission on Certification of Physician Assistants (NCCPA)

- **General Practitioners –** Practitioners who are not board certified and have not completed a training program from an accredited training program are only eligible to be considered for participation as a general practitioner in the Molina network. To be eligible, the practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five (5) years without any gaps in work history. Molina will consider allowing a practitioner who is/was board certified and/or residency trained in a specialty other than primary care to participate as a general practitioner, if the practitioner is applying to participate as a Primary Care Physician, Urgent Care or Wound Care. General practitioners providing only wound care services do not require five (5) years of work history as a PCP.
- **Nurse Practitioners & Physician Assistants –** In certain circumstances, Molina may credential a practitioner who is not licensed to practice independently. In these instances, it would also be required that the practitioner providing the supervision and/or oversight be contracted and credentialed with Molina.
- **Work History –** Practitioner must supply most recent five (5)-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six (6) months, the practitioner must clarify the gap verbally or in writing. The organization documents a verbal clarification in the practitioner's credentialing file. If the gap in employment exceeds one (1) year, the practitioner must clarify the gap in writing.
- **Malpractice History –** Practitioner must supply a history of malpractice and professional liability claims and settlement history in accordance with the application.
- **Professional Liability Insurance –** Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of malpractice and professional liability claims, and settlement history is requested from the practitioner on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.
- **State Sanctions, Restrictions on Licensure or Limitations on Scope of Practice** – Practitioner must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Practitioner must also disclose any

history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner. Molina will also verify all licenses, certifications and registrations in every state where the practitioner has practiced. At the time of initial application, the practitioner must not have any pending or open investigations from any state or governmental professional disciplinary body[3]. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.

- **Medicare, Medicaid and other Sanctions and Exclusions –** Practitioner must not be currently sanctioned, excluded, expelled or suspended from any state or federally funded program including but not limited to the Medicare or Medicaid programs. Practitioner must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner. Practitioner must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving federal contracts, certain subcontracts, and certain federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.
- **Medicare Opt Out –** Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Social Security Administration Death Master File –** Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.
- **Medicare Preclusion List –** Practitioners currently listed on the Preclusion List may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Professional Liability Insurance –** Practitioner must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina members and the practitioners activities on Molina's behalf. Practitioners maintaining coverage under a federal tort or self-insured are not required to include amounts of coverage on their application for professional or medical malpractice insurance.
- **Inability to Perform –** Practitioner must disclose any inability to perform essential functions of a practitioner in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.
- **Lack of Present Illegal Drug Use –** Practitioner must disclose if they are currently using any illegal drugs/ substances.
- **Criminal Convictions –** Practitioner must disclose if they have ever had any criminal convictions. Practitioner must not have been convicted of a felony or pled guilty to a felony for a healthcare related crime including but not limited to healthcare fraud, patient abuse and the unlawful manufacture distribution or dispensing of a controlled substance.
- **Loss or Limitations of Clinical Privileges –** At initial credentialing, Practitioner must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a

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

detailed response is required from the practitioner. At recredentialing, Practitioner must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the practitioner has had privileges since the previous credentialing cycle.

- **Hospital Privileges –** Practitioners must list all current hospital privileges on their credentialing application. If the practitioner has current privileges, they must be in good standing.
- **NPI –** Practitioner must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS).

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

Molina will notify the practitioner immediately in writing in the event that credentialing information obtained from other sources varies substantially from that submitted by the practitioner. Examples include but are not limited to actions on a license, malpractice claims history, board certification, sanctions or exclusions. Molina is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by Law.

Practitioners have the right to correct erroneous information in their credentials file. Practitioner's rights are published on the Molina website and are included in this Provider Manual.

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

- Their requirement to submit a written response within ten (10) calendar days of receiving notification from Molina.
- In their response, the practitioner must explain the discrepancy, may correct any erroneous information and may provide any proof that is available.
- The practitioner's response must be sent to Molina Healthcare, Inc. Attention: Credentialing Director at PO Box 2470, Spokane, WA 99210

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

If the practitioner does not respond within ten (10) calendar days, their application processing will be discontinued, and network participation will be administratively denied or terminated.

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

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

The practitioner must notify the Credentialing department and request an appointed time to review their file and allow up to seven (7) calendar days to coordinate schedules. A Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The practitioner has the right to review all information in the credentials file except peer references or recommendations protected by Law from disclosure.

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

Practitioner's Right to be Informed of Application Status

Practitioners have a right, upon request, to be informed of the status of their application by telephone, email or mail. Practitioner's rights are published on the Molina website and are including in this Provider Manual. Molina will respond to the request within two (2) working days. Molina will share with the practitioner where the application is in the credentialing process to include any missing information or information not yet verified.

Notification of Credentialing Decisions

Initial credentialing decisions are communicated to practitioners via letter or email. This notification is sent by the Molina Medical Director within two (2) weeks of the decision. Under no circumstance will notifications letters be sent to the practitioners later than sixty (60) calendar days from the decision. Notification of recredentialing approvals are not required.

Recredentialing

Molina recredentials every practitioner at least every thirty-six (36) months.

Excluded Providers

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

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

Ongoing Monitoring of Sanctions and Exclusions

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

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program –** Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- **State Medicaid Exclusions –** Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent).
- **Medicare Exclusion Database (MED) –** Molina monitors for Medicare exclusions through the Centers for Medicare and Medicaid Services (CMS) MED online application site.
- **Medicare Preclusion List –** Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- **National Practitioner Database –** Molina enrolls all credentialed practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- **System for Award Management (SAM) –** Monitor for Providers sanctioned with SAM.

Molina also monitors the following for all Provider types between the recredentialing cycles.

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

Provider Appeal Rights

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

13. DELEGATION

This section contains information specific to Molina's delegation criteria. Molina may delegate certain administrative responsibilities upon meeting all of Molina's delegation criteria. Molina is accountable for all aspects of the member's health care delivery, even when it delegates specific responsibilities to sub-contracted entities. Molina's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements.

If you have additional questions related to delegated functions, please contact your Molina Contract Manager.

Delegation Criteria

Credentialing

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

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

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

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

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

Delegation Reporting Requirements

Delegated entities contracted with Molina must submit monthly and quarterly reports determined by the function(s) delegated to the identified Molina Delegation Oversight Staff within the timeline indicated by the Health Plan. For a copy of Molina's current delegation reporting requirements, please contact your Molina Contract Manager.

14. PHARMACY

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

Pharmacy and Therapeutics Committee

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

Pharmacy Network

Members must use their Molina ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, limitations, and network pharmacies is available by visiting www.MolinaHealthcare.com or calling Molina at (855) 237-6178.

Drug Formulary

The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage and/or quantities. For a complete list of covered medications please visit www.MolinaHealthcare.com

Information on procedures to obtain these medications is described within this document and also available on the Molina website.

Formulary Medications

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

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

Quantity Limitations

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

Age Limits

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

Non-Formulary Medications

Non-formulary medications may be considered for exception when formulary medications are not appropriate for a particular member or have proven ineffective. Requests for formulary exceptions should be submitted using a PA form. Clinical evidence must be provided and is taken into account when evaluating the request to determine medical necessity.

Generic Substitution

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

New to Market Drugs

Newly approved drug products will not normally be placed on the formulary during their first six (6) months on the market. During this period, access to these medications will be considered through the PA process.

Medications Not Covered

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

Submitting a Prior Authorization Request

Molina will only process completed PA request forms, the following information MUST be included for the request form to be considered complete.

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

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

Fax a completed Medication PA Request form to Molina at (855) 571-3011. A blank Medication PA Request form may be obtained by accessing www.MolinaHealthcare.com or by calling (855) 237-6178.

Member and Provider "Patient Safety Notifications"

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

Specialty Pharmaceuticals, Injectable and Infusion Services

Many specialty medications are covered by Molina through the pharmacy benefit using national drug codes (NDCs) for billing and specialty pharmacy for dispensing to the patient or Provider. Some of these same medications maybe covered through the medical benefit using Healthcare Common Procedure Coding System (HCPC) J-codes via paper or electronic medical claim submission.

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

If it is determined to be a Pharmacy benefit, Molina's pharmacy vendor, CVS Caremark Specialty Pharmacy, will coordinate with Molina and ship the prescription directly to your office or the member's home. All packages are individually marked for each member, and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes and alcohol swabs) with each prescription at no charge. Please contact your Provider Relations representative with any further questions about the program.

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

Pain Safety Initiative (PSI) Resources

Safe and appropriate opioid prescribing and utilization is a priority for all of us in health care. Molina requires Providers to adhere to Molina's drug formularies and prescription policies designed to prevent abuse or misuse of high-risk chronic pain medication.

Providers are expected to offer additional education and support to members regarding Opioid and pain safety as needed.

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

15. RISK ADJUSTMENT MANAGEMENT PROGRAM

What is Risk Adjustment?

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

This process helps ensure health plans receive accurate payment for services provided to Molina members and prepares for resources that may be needed in the future to treat members who are considered 'high risk'.

Why is Risk Adjustment Important?

Molina relies on our Provider Network to take care of our members based on their health care needs. Risk Adjustment looks at a number of clinical data elements of a member's health profile to determine any documentation gaps from past visits and identifies opportunities for gap closure for future visits. In addition, Risk Adjustment allows us to:

- Focus on quality and efficiency
- Recognize and address current and potential health conditions early
- Identifies members for Case Management referral
- Ensures adequate resources for the acuity levels of Molina members
- To have the resources deliver the highest quality of care to Molina members

Your Role as a Provider

As a Provider, your complete and accurate documentation in a member's medical record and submitted claims are critical to a member's quality of care. We encourage providers to code all diagnoses to the highest specificity as this will ensure Molina receives adequate resources to provide quality programs to you and our members.

For a complete and accurate medical record, all Provider documentation must:

- Address clinical data elements provided by Molina and reviewed with the patient.
- Be compliant with CMS correct coding initiative.
- Use the correct ICD-10 code by coding the condition to the highest level of specificity.
- Only submit codes for diagnoses confirmed during a face to face visit with the member.
- Contain a treatment plan.
- Be clear and concise.
- Contain the member's name and date of service.
- Have the physician's signature and credentials.

RADV Audits

As part of the regulatory process, State and/or Federal agencies may conduct Risk Adjustment Data Validation (RADV) audits to ensure that the diagnosis data submitted by Molina is appropriate and accurate. All claims/encounters submitted to

Molina are subject to State and/or Federal and internal health plan auditing. If Molina is selected for a RADV audit, providers will be required to provide medical records in a timely manner to validate the previously submitted data.

Contact Information

For further questions about Molina's Risk Adjustment programs, please contact our team at: RiskAdjustment.Programs@MolinaHealthcare.com