PROVIDER MANUAL

(Provider Handbook)

Molina Healthcare of South Carolina, Inc.

(Molina Healthcare or Molina)

Medicaid

2026

Capitalized words or phrases used in this Provider Manual shall have the meaning set forth in your Agreement with Molina Healthcare. "Molina Healthcare" or "Molina" have the same meaning as "Health Plan" in your Agreement. The Provider Manual is customarily updated annually but may be updated more frequently as needed. Providers can access the most current Provider Manual at MolinaHealthcare.com.

Last Updated: 9/2026

MOLINA® HEALTHCARE

Contents

Section 1	Contact information	1
Section 2	Eligibility, enrollment, disenrollment	5
Section 3	Member rights and responsibilities (member bill of rights)	10
Section 4	Benefits and covered services	11
Section 5	Provider responsibilities	30
Section 6	Culturally and linguistically appropriate services	41
Section 7	Health Care Services (hcs)	47
Section 8	Behavioral Health	75
Section 9	Medical management	79
Section 10	Pharmacy	81
Section 11	Quality	86
Section 12	Risk adjustment accuracy and completeness	103
Section 13	Claims and compensation	105
Section 14	Compliance	121
Section 15	Credentialing and recredentialing	150
Section 16	Delegation	160
Section 17	Appeals and grievance process	163

Section 1 Contact information

Molina Healthcare of South Carolina, Inc.

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

Provider Services

The Molina Provider Services handles telephone inquiries from Providers regarding claims, appeals, authorizations, eligibility, and general concerns. Molina Provider Services representatives are available Monday – Friday, 8 a.m.-5 p.m., EST, excluding state and federal holidays.

Molina strongly encourages participating Providers to submit Claims electronically (via a clearinghouse or the Availity Essentials portal whenever possible.

EDI Payer ID Number: 46299

To verify the status of your Claims please use the Availity Essentials portal. Claim questions can be submitted through the Secure Messaging feature via the Claims Status module on the Availity Essentials portal, or by contacting Molina Provider Services.

Eligibility verifications can be conducted at your convenience via the Eligibility and Benefits module on the Availity Essentials portal.

Phone: (855) 237-6178
Availity Essentials portal: Availity.com/providers
Hearing impaired (TTY/TDD): 711

Provider Relations

The Provider Relations department manages Provider calls regarding issue resolution, Provider education and training. The department has Provider Relations representatives who serve all of Molina's Provider network.

Member Services

The Molina Member Services handles all telephone and written inquiries regarding benefits, eligibility/identification, Pharmacy inquiries, selecting or changing Primary Care Providers (PCPs), and Member complaints. Molina Member Services representatives are available from 8 a.m.-6 p.m. Monday through Friday, excluding state and federal holidays.

Phone: (855) 882-3901
Hearing impaired (TTY/TDD): 711
Fax: (844) 834-2155

Claims

Molina strongly encourages participating Providers to submit Claims electronically via a clearinghouse or the Availity Essentials portal whenever possible.

- Availity Essentials portal: Availity.com/providers
- EDI Payer ID 46299

To verify the status of your Claims, please use the Availity Essentials portal. Claim questions can be submitted through the Secure Messaging feature via the Claims Status module on the Availity Essentials portal or by contacting Molina Provider Services.

Phone: (855) 237-6178

Claims Recovery

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

Provider Disputes	Molina Healthcare of South Carolina PO Box 2470 Spokane, WA 99210-2470
Refund Checks Lockbox	Molina Healthcare of South Carolina PO Box 602960 Charlotte, NC 28260-2960
Phone	(866) 642-8999
Claims Recovery Fax Number	(877) 480-1127

Compliance and fraud alertline

Suspected cases of fraud, waste, or abuse must be reported to Molina. You may do so by contacting the Molina Alertline or by submitting an electronic complaint using the website listed below. For more information about fraud, waste and abuse, please see the Compliance section of this Provider Manual.

Confidential
Compliance Official
Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802
Phone: (866) 606-3889
Online: MolinaHealthcare.Alertline.com

Credentialing

The Credentialing department verifies all information on the Provider Application prior to contracting and re-verifies this information every three years, or sooner, depending on Molina's

Credentialing criteria. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Molina network. For additional information about Molina's Credentialing program, including Policies and Procedures, please refer to the Credentialing and Recredentialing section of this Provider Manual.

Email: MSC-CREDENTIALING@MolinaHealthcare.com
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 24 hours a day, 7 days a week.

(844) 800-5155
Hearing impaired (TTY/TDD): 711

Health Care Services (HCS)

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

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

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

Molina offers the following electronic prior authorizations/service requests submission options:

- Submit requests directly to Molina via the Availity Essentials portal.
- Submit requests via 278 transactions. See the EDI transaction section of Molina's website for guidance.

Availity Essentials portal: Availity.com/providers
Prior Authorization Fax: (866) 423-3889

- Advanced Imaging: (877) 731-7218
- Transplants: (877) 813-1206

Behavioral health

Molina manages all components of covered services for behavioral health. For Member behavioral health needs, please contact us directly at (855) 882-3901 (TTY: 711). Molina has a Behavioral Health Crisis Line that Members may access 24 hours per day, 365 days per year by calling the Member Services telephone number on their Molina ID card.

Pharmacy

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

Phone: (855) 237-6178

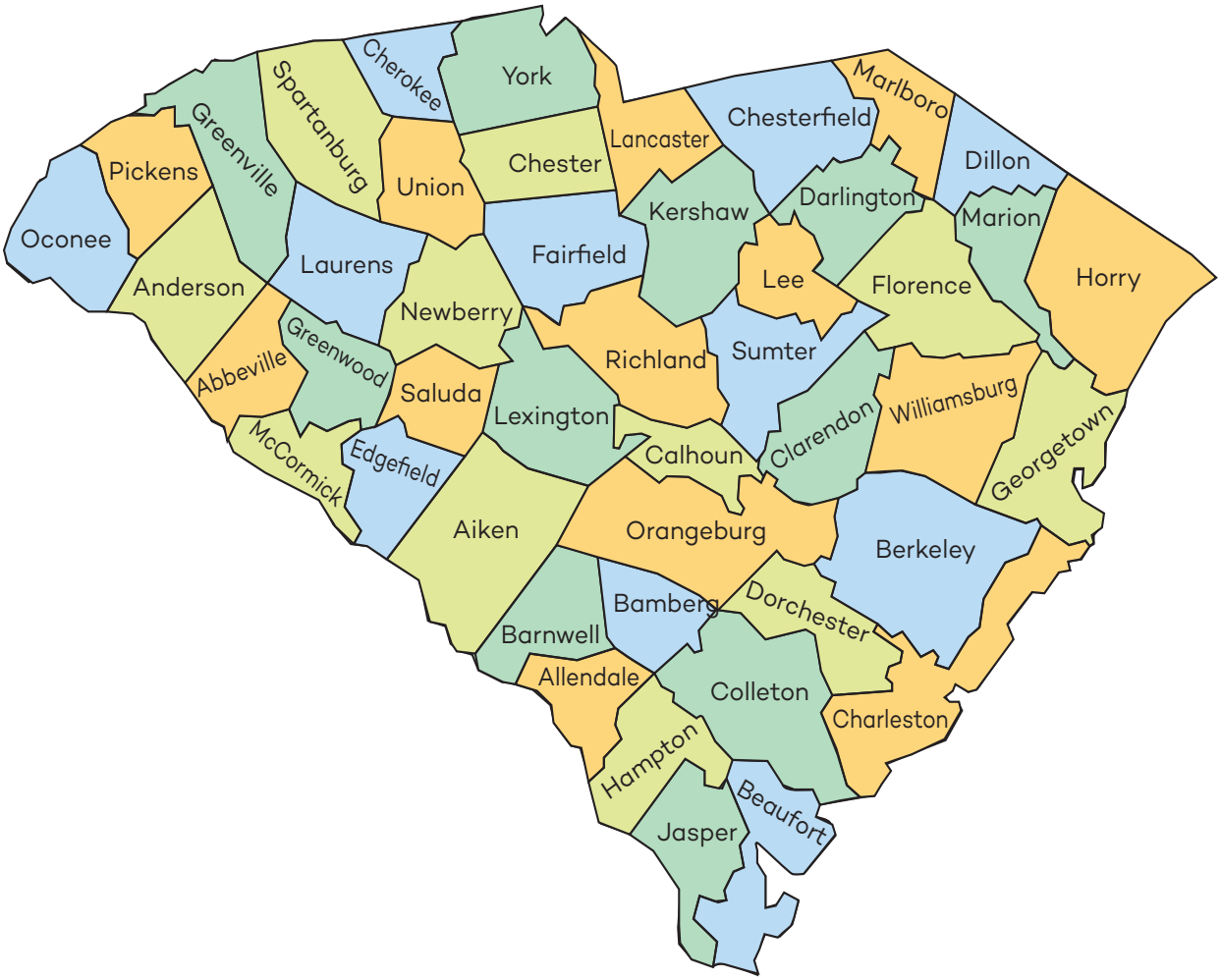
Quality

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

Phone: (855) 237-6178

Molina Health Care of South Carolina, Inc. service area

Includes all 46 counties



Section 2 Eligibility, enrollment, disenrollment

Enrollment in Medicaid programs

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

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

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

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

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

Newborn enrollment

All newborns of Molina Members, where the newborn resided in the same household as the mother, are the responsibility of Molina. To assure continuity of care in the first months of the newborn's life, every effort will be made by SCDHHS to expedite the enrollment of the newborn

into Molina. In cases where the newborn is not living with the mother, the newborn will be covered through fee-for-service Medicaid or be enrolled into a health plan by the person legally responsible for the newborn.

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

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

Inpatient at time of enrollment

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

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

Eligibility verification

Medicaid programs

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

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

The program is limited to certain Medicaid eligibles who:

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

Eligibility listing for Medicaid programs

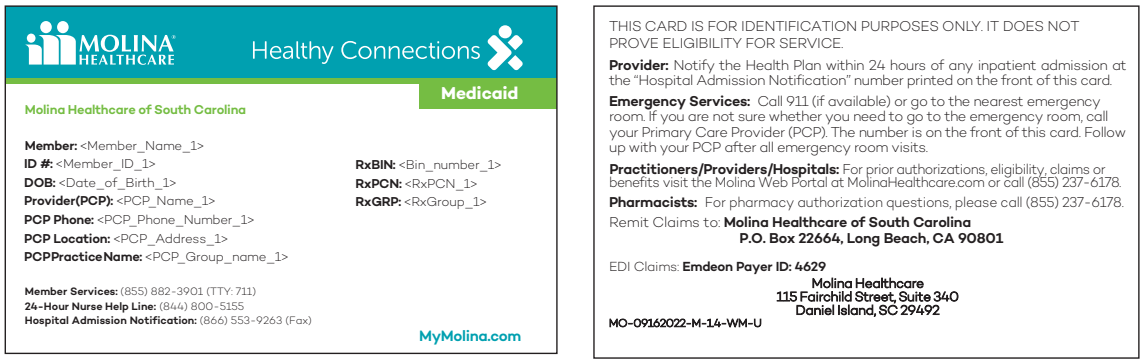
Providers who contract with Molina may verify a Member's eligibility and/or confirm Primacy Care Provider (PCP) assignment by checking the following:

- Molina Provider Services at (855) 237-6178
- Eligibility can also be verified through the State by visiting portal.scmedicaid.com/
- Availity Essentials portal: Availity.com/providers

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

Identification cards

Molina Healthcare of South Carolina Sample Member ID card



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

Disenrollment

Voluntary disenrollment

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

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

Involuntary disenrollment

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

- Molina ceases participation in the Medicaid Program in the Member's service area
- Member has moved out of the service area
- Member death
- Member becomes an inmate of a public institution
- Member elects Hospice
- Member's behavior is disruptive, abusive, or uncooperative and continued enrollment impairs the ability to furnish services to this Member or other Members
- Member's utilization of services is fraudulent or abusive
- Member is placed in a long-term care nursing facility/nursing home for more than 90 continuous days
    - Long-term nursing facility services are managed and paid by SCDHHS under fee-for-service Medicaid; the MCO is responsible only for medical services per SCDHHS carve-in guidance.
- Member elects home-and community-based Waiver programs
- Member's Medicaid eligibility category changes or Member otherwise becomes ineligible to participate in Medicaid
- Member becomes age 65 or older
- Member becomes Medicare eligible
- Member enrolls in a commercial MCO
- Member is placed out of home into an Intermediate Care Facility for the Intellectually Disabled

PCP initiated member dismissal

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

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

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

Missed appointments

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

A Member may only be considered for an involuntary disenrollment from a Provider's panel after the Member has had at least one verbal warning and at least one written warning of the full implications of his or her failure of actions. The Member must receive written notification in sixth grade reading level from the PCP explaining in detail the reasons for dismissal from the practice. Action related to request for involuntary disenrollment conditions must be clearly documented by Providers in the Member's records and submitted to Molina. The documentation must include attempts to bring the Member into compliance. A Member's failure to comply with a written corrective action plan must be documented. For any action to be taken, it is mandatory that copies of all supporting documentation from the Member's file are submitted with the request. Molina will contact the Member to educate the Member in the consequences of behavior that is disruptive, unruly, abusive or uncooperative and/or assist the Member in selecting a new PCP. The current PCP must provide emergency care to the Member until the Member is transitioned to a new PCP.

PCP assignment

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

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

PCP changes

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

Section 3 Member rights and responsibilities (member bill of rights)

Molina members have rights and responsibilities that have been provided by SCHC. South Carolina law requires that health care Providers or health care facilities recognize Member rights while they are receiving medical care and that Members respect the health care Provider's or health care facility's right to expect certain behavior on the part of patients. In South Carolina, these rights are known as the Member Bill of Rights.

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

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 the Molina Provider Services at (855) 237-6178, Monday – Friday, 8 a.m.-5 p.m., EST. TTY/TDD: users, please call 711 for persons with hearing impairments.

Second opinions

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

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

Section 4 Benefits and covered services

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

There are no copays or cost sharing for Molina Members for any services, no matter what type it is or where they get it.

Some benefits may have limitations. If there are questions as to whether a service is covered or requires Prior Authorization, please reference the prior authorization tools located on the Molina website and the Availity Essentials portal. You may also contact Molina at (855) 237-6178, Monday–Friday, 8 a.m.-5 p.m., local time.

Member benefits and covered services can be found in the grid below. For a comprehensive list of enhanced value-added member benefits, please visit Molina's member website at MolinaHealthcare.com/SC-Rewards.

Services covered by Molina

Services	Coverage	Limits/Exclusions
Alcohol, Drug, and Substance Use Services	Covered. Alcohol, drug, and substance use treatment services are provided by the Department of Alcohol and Other Drug Abuse Services (DAODAS).	
Ambulance Services	Covered. Emergency transportation given by: • Ambulance • Air ambulance	
Ancillary Medical Services	Covered. Includes health services ordered by a provider, including but not limited to, laboratory services, radiology services and physical therapy. Example: anesthesiology	

Services	Coverage	Limits/Exclusions
Audiological Services	Services include: • Examinations • Fittings and related audiology services • Diagnosis, screening, preventive and corrective services for members who are hearing-impaired or to determine if they are hearing-impaired.	Only covered for children under 21 years of age.
Autism Spectrum Disorder	Covered. • Behavior Identification Assessment • Adaptive Behavior Treatment by Protocol • Adaptive Behavior Treatment with Protocol Modification • Family Adaptive Behavior Treatment Guidance	
BabyNet	Covered based on guidelines from the South Carolina Department of Health and Human Services (SCDHHS).	
Breast Cancer Screening	Covered. Covered once every two years, starting at age 40 and continuing through age 74.	
Chiropractic Services	Covered. Limited to manual manipulation of the spine using the hands to put the bones of the spine back in line.	Limited to 6 visits per year. 2 x-ray procedures per State fiscal year.
Communicable Disease Services	Covered. Exams and reviews including, but not limited to: • Taking steps to find out what's wrong with the Member and treat them • Contact tracing • Counseling and health education • Directly Observed Therapy (DOT) for tuberculosis (TB) cases. Help control and prevent diseases such as TB, syphilis, and other sexually transmitted infections (STIs) and HIV/AIDS	NOTE: These services can also be received at Department of Health and Environmental Control (DHEC).

Services	Coverage	Limits/Exclusions
Disease Management	Covered. This includes keeping track of any medical conditions/diseases and educating the Member about available treatment options. Molina provides access to disease management programs. Examples are: • Breathe with Ease Asthma Management Program (for children and adults) • Building Brighter Days Depression Management Program (for adults) • Sickle Cell Disease Program	
Developmental Evaluation Centers (DEC)	Covered. DECs help children up to 21 years old who learn and grow differently. They check how a child's brain is developing and how they feel and think. This may include cognitive and psychological evaluations, screenings, and coordination care. The number of times a Member can receive services depends on the type of service they receive.	Member must be referred by a physician or other licensed healing arts practitioner.

Services	Coverage	Limits/Exclusions
Durable Medical Equipment and Supplies	Covered when medically necessary. Equipment may require Prior Approval from the Member's doctor. Medically necessary equipment and supplies, including: • Medical products • Surgical supplies • Wheelchairs • Traction equipment • Walkers • Canes • Crutches • Ventilators • Prosthetic devices • Orthotic devices • Oxygen • Hearing aids and accessories • Diabetes supplies • Incontinence supplies • Any other items when ordered by a doctor as medically necessary	Hearing aids and hearing aid accessories only covered for members under age 21.
Emergency Medical Services	Covered. For medical emergencies, members should call 911 or go to the nearest emergency room. For non-urgent services, members are advised to notify their Primary Care Provider (PCP) about any follow-ups or changes to their care after visiting the ER. All emergency services are covered. Approval from Molina is not needed for any emergency services.	

Services	Coverage	Limits/Exclusions
Family Planning	Covered. This includes medical visits for birth control: • Teaching Members about family planning • Counseling • Birth control drugs and supplies • Pregnancy tests • Lab tests • Tests for sexually transmitted infections (STIs) • Sterilization • Teen pregnancy prevention program	Molina does not cover surgery to reverse sterilization. It is best to receive family planning services from a participating Molina provider. However, eligible members can receive these services from any appropriate provider without restrictions. Hysterectomies are covered only when medically necessary, not for pregnancy prevention. Sterilizations require Members to be 21+, mentally competent, and to have given consent. Abortions are covered in cases of rape or incest, if the pregnancy poses a health risk, or if the Member's life is endangered by the pregnancy.

Services	Coverage	Limits/Exclusions
Health Care Screenings for Adults	Covered. • Mammography screening • Prostate cancer screening • Cholesterol screening • Vaccine services (i.e., Influenza, pneumococcal, hepatitis) • Cervical cancer screenings • Chlamydia screening • Prenatal visits Female Members may receive routine and preventive care from a women's health specialist (i.e., OB/GYN) in addition to services by their PCP.	
Hearing Exams, Hearing Aids and Hearing Aid Accessories	Covered for members under age 21. • Hearing exams • Hearing aids and supplies	Only for children under 21 years of age.
Home Health Services	Covered. Medical visits that take place in the home, which can include: • Skilled nursing • Home health aides • Medical supplies and equipment fit for use in the home • Physical, occupational and speech therapy • Supplies ordered by a doctor	Limited to 50 visits per year.

Services	Coverage	Limits/Exclusions
Hospitalization including services normally provided by the hospital	Covered. All hospital services must be ordered by a doctor. These hospital services may include: • A semi-private room • Maternity services • Special treatment rooms • Operating rooms • Supplies • Medical tests and x-rays • Drugs the hospital gives the Member during their stay • Giving the Member someone else's blood • Radiation therapy • Chemotherapy • Dialysis treatment • Meals and special diets • General nursing services • Anesthesia • Anesthesia for dental procedures when it is an emergency • Setting up a plan for when the Member leaves the hospital (this includes future care if they need it) • Rehabilitation in the hospital	Private rooms are not covered unless medically necessary.
Laboratory Exams and X-rays	Covered. Medically necessary lab and x-ray services ordered by the Member's provider.	
Long Term Care/Nursing Home Facilities	Covered when the member is approved for and enter a long-term care or nursing home facility. These services are managed by South Carolina Department of Health and Human Services (SCDHHS).	

Services	Coverage	Limits/Exclusions
Maternity Services	Covered. This may include the following services: • Doctor visits and all expert care for pregnancy, problems that have to do with pregnancy and after-delivery care when medically necessary • Services Members get from a certified nurse-midwife • Tests the Member needs such as sonograms • HIV testing, treatment and counseling (A pregnant member may refuse to take an HIV test) • Birthing center services • Vaginal childbirth and Cesarean section (C-section) • Newborn hearing screenings	
Newborn Hearing Screening	Covered for Members up to six months of age in either inpatient or outpatient setting without Prior Authorization. Must be performed within the first six months of life.	
Outpatient Pediatric AIDS Clinic Services (OPAC)	Covered. Services for HIV-related and exposed children and their families including: • Specialty care • Consults • Counseling • Clinical and lab tests	

Services	Coverage	Limits/Exclusions
Outpatient Services	Covered. Services must be ordered by a doctor and may include: • Care to prevent illness • Care to treat the Member's health issue • Rehabilitation • Surgical care • Emergency care • Treatment of renal disease • Neurodevelopmental or mental developmental assessment and testing • Dialysis • Emergency room use for emergency conditions • Drugs ordered by a doctor • Giving the Member replacement blood • Services to prevent problems or find out what is wrong with the Member • Surgery without an overnight hospital stay • Sterilization	Neurodevelopmental or mental developmental assessments and testing are only for eligible Members under 21 years of age.
Post Stabilization Services	Covered. If a Member has an emergency, Molina covers medical help that's needed to keep the Member stable or until they leave the hospital. This help continues until a Molina doctor at the hospital takes over their care, or until a Molina doctor decides to transfer the Member somewhere else for care, or until the Molina Medical Director and the doctor treating the Member agree on how to take care of them. These services are covered whether inside or outside Molina's service area if related to an emergency medical condition.	The treating doctor must submit requests for post stabilization services to Molina by calling (855) 237-6178.
Prescription Drugs	Covered.	An approval from Molina is required for some drugs. Some drugs are not covered. Check the Comprehensive Drug List (CDL).

Services	Coverage	Limits/Exclusions
Physician Services	Covered. This includes services provided by a Physician or nurse practitioner or Rural Health Clinic – RHC or Federally Qualified Health Center – FQHC. Adult well visits for Members over age 21 covered one time each year.	
Psychiatric Residential Treatment Facility (PRTF) Services	The following services are covered: • General Room and Board • Semi Private • Ward Psychiatric and psychological sessions, screenings, medication training and support, and crisis intervention.	Therapeutic Home Time (THT) limited to 14 days per year.
Podiatry Services	Covered for certain medical conditions for Members of all ages.	
Rehabilitative Behavioral Health Services (RBHS)/ Mental Health Services	Covered. • Psychological Evaluations • Outpatient Psychotherapy • Medication Management (provided by Medical Doctor or nurse practitioner) • Specialty Pharmacy Drugs (injectable) • Community Support • Consultations/Conferences • Psychological Testing • Neuropsychological Testing • Crisis Intervention Services	
Rehabilitative Services for Children	Services include non-hospital related services such as: physical therapy, occupational therapy, speech therapy, audiology and nursing services. Children who may have medical risk factors can have their: • Health status assessed • Risk factors identified • Goal-oriented plan of care written or changed	

Services	Coverage	Limits/Exclusions
Syphilis screening during pregnancy	Covered. Covered at the first prenatal care visit, once during the third trimester, and at birth of baby.	Covered for up to 3 screenings during each pregnancy.
Transplant Services	Covered. Must have approval from a doctor before transplant can be performed. Types of transplants include: • Kidney • Corneal • Bone Marrow (Autologous Inpatient and Outpatient, Allogeneic Related and Unrelated, Cord, and Mismatched) • Pancreas • Heart • Liver • Liver with Small Bowel • Liver/Pancreas • Liver/Kidney • Kidney/Pancreas • Lung and Heart/Lung • Multivisceral • Small Bowel	Corneal transplants do not require prior approval from the Member's doctor. If the Member has any special needs after their transplant that require prior approval from their doctor, Molina will review these needs after the procedure. Examples of special needs may include a wheel chair or home health services.
Vision Services	Covered.	
Well-child Visits for Children including Early and Periodic Screening, Diagnosis and Treatment/ Well-child Services (EPSDT) Please see the Quality chapter of this Manual for more details on EPSDT	Covered only for children through the month of their 21st birthday. Preventive health care services include: • Health screens • Physical exams • Vaccines • Lab tests, including blood lead level • Teaching about health topics • Hearing tests • Dental screenings • Vision screenings	Well-child visits end on the month of the child's 21st birthday.

Fee-for-Service (Non-Managed) Medicaid Services

The services listed below are not managed, authorized, or reimbursed by Molina Healthcare. These services are covered and paid directly by the South Carolina Department of Health and Human Services (SCDHHS) under fee-for-service Medicaid.

Providers should bill SCDHHS directly for these services and follow applicable SCDHHS Medicaid policies.

Molina may assist with care coordination but does not assume financial responsibility for these services.

Services covered by SCDHHS through fee-for-service Medicaid

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

Services not covered

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

Prescription drugs

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

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

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

Drug exception request process

The Provider may request a Prior Authorization for clinically appropriate drugs that are not listed on the CDL. Using the FDA label, community standards, and high levels of published clinical evidence, clinical criteria are applied to requests for medications requiring Prior Authorization.

Specialty drug services

Many specialty medications are covered by Molina through the pharmacy benefit using National Drug Codes (NDC) for billing and specialty pharmacy for dispensing to the Member or Provider.

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

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. Additional information about our Prior Authorization process, including a link to the PA request form, please refer to the **Pharmacy** section of this Provider Manual. Physician administered drug claims require the appropriate NDC number with the exception of vaccinations or other drugs as specified by CMS.

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

Access to behavioral health services

Members in need of Behavioral Health Services may access them through PCP referral or Members can self-refer. If assistance is needed locating a Provider, Members can call Molina's Member Services at (855) 882-3901 (TTY: 711). Molina's Nurse Advice Line is available 24 hours a day, 7 days a week, 365 days per year for mental health or substance abuse needs. The services Members receive will be confidential.

Additional detail regarding Covered Services and any limitations can be obtained in the benefit information linked above, or by contacting Molina. If in-patient services are needed, prior authorization must be obtained, unless the admission is due to an emergency situation, and inpatient Member cost share will apply.

Emergency mental health or substance use disorder services

Members are directed to call 988, 911, or go to the nearest emergency room (ER) if they need emergency mental health or substance abuse services. Examples of emergency mental health or substance abuse problems are:

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

Out of area emergencies

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

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

Emergency and ambulance transportation

When a Member's condition is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while 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 does not provide non-emergency medical transportation. Non-emergency medical transportation is available to qualified individuals through the SCDHHS transportation broker system.

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

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

If your Member needs further assistance, they can also call Molina Member Services at (855) 882-3901 (TTY: 711), and one of our representatives will assist them.

Preventive care

Preventive Care Guidelines are located on the Molina website at MolinaHealthcare.com/providers/sc/medicaid/resource/prevent/prevent.aspx

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

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

Immunizations

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

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

Immunization	Ages
Hepatitis B (Hep B)	Birth, 1–2 months, and 6–18 months
Rotavirus (RV)	2 months, 4 months and 6 months
Diphtheria, Tetanus, Pertussis (DTaP)	2, 4, 6, 15–18 months and one between the ages of 4–6 years
Haemophilus influenza type b (HIB)	2, 4, 6 and 12–15 months
Pneumococcal (PCV)	2, 4, 6 and 12–15 months

Immunization	Ages
Inactivated Poliovirus (IPV)	2, 4, 6–18 months and one between the ages 4–6 years
Influenza	6 months–18 years, yearly (consult your PCP)
Measles, Mumps, Rubella (MMR)	12–15 months and one between the ages of 4–6 years
Varicella	12–15 months and one between the ages of 4–6 years
Hepatitis A (Hep A)	Two (2) doses between 12–24 months
Tetanus, Diphtheria, Pertussis (Tdap)	11–12 years
Human Papilloma Virus (HPV)	Two (2) doses if under 15 years and three (3) doses if 15 years and older
Meningococcal (MCV)	One (1) dose between 11–12 years and one (1) dose at 16 years

Well-child visits and Early Periodic Screening Diagnosis and Treatment (EPSDT) guidelines

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

The screening services include:

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

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

We need your help conducting these regular exams in order to meet the South Carolina Department of Health and Human Services targeted State standard. Providers must use correct coding guidelines to ensure accurate reporting for EPSDT services. If you have questions or suggestions related to EPSDT or well childcare, please contact your Provider Services representative.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	Infants (0–18) months	Children (2–6) years	Adolescents (7–21) years
Physical Exam and Health History	• History • Height • Weight • Physical exam • Oral Health • Body Mass Index (BMI) • Blood Pressure	• History • Height • Weight • Physical exam • Oral Health • Body Mass Index (BMI) • Blood Pressure	• History • Height • Weight • Physical exam • Oral Health • Body Mass Index (BMI) • Blood Pressure
Development and Behavior Assessment	• Gross motor • Fine motor • Social/emotional • Nutritional • (any one of these)	• Gross motor • Fine motor • Communication • Self-help skills • Cognitive skills • Social/emotional • Regular physical activity • Nutritional (any one of these)	• Social/emotional • Regular physical activity • Nutritional • (any one of these)
Mental Health Assessment	Mental health (must be addressed)	Mental health (must be addressed)	• Mental health • Substance abuse (either one of these)

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	Infants (0–18) months	Children (2–6) years	Adolescents (7–21) years
Health Education/ Anticipatory Guidance	• Injury prevention • Passive smoking (either one of these)	• Injury prevention • Passive smoking (either one of these)	• Injury prevention • STD prevention • Smoking/tobacco (any one of these)
Health Reward Offered	✓	✓	✓

Prenatal care

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

Emergency services

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

24-hour Nurse Advice Line

Members may call the Nurse Advice Line anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, 7 days a week, 365 days a year.

(844) 800-5155 (TTY: 711)

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 of the health care system.

Health management programs

Molina offers programs to help our Members and their families manage various health conditions.

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

Telehealth and Telemedicine services

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

- Services must be obtained from a Participating Provider.
- Members have the option of receiving PCP services through telehealth. If they choose to use this option, the Member must use a Network Provider who offers telehealth.
- 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 must be coded in accordance with applicable reimbursement policies and billing guidelines.
- Rendering Provider must comply with applicable federal and state guidelines for telehealth service delivery.

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

Section 5 Provider responsibilities

Nondiscrimination in health care service delivery

Providers must comply with the nondiscrimination in health care service delivery requirements as outlined in the Culturally and Linguistically Appropriate Services section of this Provider Manual.

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

Ethical Considerations

In accordance with our contract with the South Carolina Department of Health and Human Services, Molina is required to identify providers who decline to offer certain services due to moral or religious objections, including family planning services. Providers are required to notify Molina if they have any objections that could prevent them from delivering specific services to Molina Members. This notification should be provided promptly to ensure that appropriate arrangements can be made for Members' care. Failure to notify Molina of such objections may impact the provider's continued participation in the network. If you have any objections, please send the following information to SCProvider.Services@MolinaHealthcare.com.

- Provider NPI
- Provider NPI (Individual or Facility)
- Provider Name (Individual or Facility)
- Details on Moral or Religious Objections

Section 1557 investigations

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

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

Phone: (866) 606-3889
TTY/TDD: 711

Online: MolinaHealthcare.Alertline.com
Email: civil.rights@MolinaHealthcare.com

For additional information, please refer to the Department of Health and Human Services (HHS) website at: federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority

Facilities, equipment, personnel and administrative services

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). The Americans with Disabilities Act requires access to the facilities where medical services are provided. As a provider, you are required to inform Molina Healthcare of South Carolina Network Administration by emailing SCNetworkAdministration@MolinaHealthcare.com if you are not ADA compliant or handicap accessible and provide what alternative accommodations are being offered to Molina members.

Provider data accuracy and validation

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

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement, as well as a National Committee for Quality Assurance (NCQA) required element. Invalid information can negatively impact Member access to care, Member/PCP assignments and referrals. Additionally, current information is critical for timely and accurate Claims processing. A Molina Member may request a free printed copy of the Provider Directory at any time by contacting Member Services.

Please visit our Provider Online Directory at molina.sapphirethreesixtyfive.com/?ci=sc-medicaid&locale=en&network_id=31&geo_location=41.4796000000000005,-81.511 to validate your information. Providers must validate their Provider information on file with Molina at least once every 90 days for correctness and completeness. Additionally, in accordance with the terms specified in your Provider Agreement, Providers must notify Molina of any changes, as soon as possible, but at a minimum thirty (30) calendar days in advance of any changes in any Provider information on file with Molina. Changes include, but are not limited to:

- Change in office location(s)/address, office hours, phone, fax, or email.
- If a provider is no longer seeing patients at specific service location.
- Addition or closure of office location(s).
- Addition of a Provider (within an existing clinic/practice).
- Change in Provider or practice name, TaxID and/or National Provider Identifier (NPI).
- Opening or closing your practice to new patients (PCPs only).
- Change in specialty.
- Any other information that may impact Member access to care.

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

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

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

All Molina Providers participating in a Medicaid network must be enrolled in the state Medicaid program to be eligible for reimbursement. If a Provider has not had a Medicaid number assigned, the Provider must apply for enrollment with the South Carolina Department of Health and Human Services (SCDHHS) and meet the Medicaid Provider enrollment requirements set forth in the Healthy Connections Visual Enrollment Guide for fee-for-service Providers of the appropriate provider type.

Provider Notification: Disclosure of Ownership Requirement

In accordance with 42 CFR 455.104, if you are not enrolled with SCDHHS as a South Carolina Medicaid Network Provider, including SCAs, non-Medicaid enrolled providers, and subcontractors, you are required to provide full ownership and disclosure information upon execution of the Subcontract. Additionally, any ownership changes must be reported within thirty-five (35) days to Molina.

The SCDHHS Ownership Form (SCDHHS Form 1514) can be found on Molina's website at MolinaHealthcare.com under the Medicaid Provider section, Forms. Please complete and return this form to Molina by fax at (843) 740-1748 or via email at MSC-CREDENTIALING@MolinaHealthcare.com. Be mindful that failing to disclose this information may affect your eligibility to participate in future agreements with Molina. If you have any questions, please contact the Credentialing department for assistance.

National Plan and Provider Enumeration System (NPPES) data verification

In addition to the above verification requirements, CMS recommends that Providers routinely verify and attest to the accuracy of their NPPES data.

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

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

Molina electronic solutions requirements

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

Molina encourages all contracted Providers to participate in and comply with Molina's Electronic Solution requirements, which include, but are not limited to, electronic submission of prior authorization requests, prior authorization status inquiries, health plan access to electronic medical records (EMR) electronic Claim submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic Claims appeal and registration for and use of the Availity Essentials portal.

Electronic Claims include Claims submitted via a clearinghouse using the EDI process and Claims submitted through the Availity Essentials portal.

Any Provider entering the network as a Contracted Provider will be encouraged to comply with Molina's electronic solution policy by enrolling for EFT/ERA payments and registering for the Availity Essentials 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 MolinaHealthcare.com.

Electronic solutions/tools available to providers

Electronic Tools/Solutions available to Molina Providers include:

- Electronic Claim submission options
- Electronic payment: EFT with ERA
- Availity Essentials portal: Availity.com/providers

Electronic claims submission requirement

Molina strongly encourages participating Providers to submit Claims electronically. Electronic Claim submission provides significant benefits to the Provider such as:

- Promoting HIPAA compliance
- Helping to reduce operational costs associated with paper Claims (printing, postage, etc.)
- Increasing accuracy of data and efficient information delivery
- Reducing Claim processing delays as errors can be corrected and resubmitted electronically
- Eliminating mailing time and enables Claims to reach Molina faster

Molina offers the following electronic Claim submission options:

- Submit Claims directly to Molina of State via the Availity Essentials portal.

- Submit Claims to Molina through your EDI clearinghouse using Payer ID 46299, or refer to our website, MolinaHealthcare.com, for additional information.

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

Availity Essentials portal Claim submission includes the ability to:

- Submit Claims through direct data entry
- Add attachments to Claims
- Submit Claims through quick Claims entry and saving templates
- Submit corrected Claims
- Add attachments to corrected Claims
- Add attachments to pending Claims
- Easily and quickly void Claims
- Check Claim 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 additional information on EDI Claim submission and paper Claim submission, see the **Claims and Compensation** section of this Provider Manual.

Electronic payment requirement

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

Molina has partnered with ECHO Health, Inc. (ECHO), for payment delivery and 835 processing. On this platform you may receive your payment via EFT/Automated Clearing House (ACH), a physical check, or a virtual card.

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

If you would like to opt-out of receiving a virtual card prior to your first payment, you may contact Molina and request that your Tax ID for payer Molina Healthcare of South Carolina be opted out of virtual cards.

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

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

As a reminder, Molina's Payer ID is 46299.

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

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

Availity Essentials portal

Providers and third-party billers can use the no cost Availity Essentials portal to perform many functions online without the need to call or fax Molina. Registration can be performed online and once completed the easy to use tool offers the following features:

- Verify Member eligibility, covered services and view HEDIS® needed services (gaps)
- Claims:
    - Submit Professional (CMS1500) and Institutional (CMS-1450 [UB04]) Claims with attached files
    - Correct/void Claims
    - Add attachments to previously submitted Claims
    - Check Claim status
    - View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
    - Create and manage Claim templates
    - Submit and manage Claim disputes, including formal appeals or reconsideration requests, for finalized Claims
    - View, dispute, resolve Claim overpayments
- Prior authorizations/service requests
    - Create and submit prior authorization/service requests
    - Check status of authorization/service requests

    - Access prior authorization letters directly through the Digital Correspondence Hub functionality in the Availity Essentials portal. Please note: Letters will only be available for prior authorization requests submitted via the Availity Essentials portal.
- Download forms and documents
- Send/receive secure messages to/from Molina
- Manage overpayment invoices (Inquire, Dispute and Resolve)

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

Digital Correspondence Hub

The Digital Correspondence Hub lets your organization manage communication preferences in the Availity Essentials portal. Only your designated Administrator can change settings, including opting out of paper letters. For updates, please contact your Administrator.

Users can also choose to receive or decline weekly reminder notifications for unopened digital letters. These reminders are not realtime alerts. Opting out of reminders does not affect your organization's digital correspondence delivery preferences.

Provider network management portal: enrollment tool

The Provider Network Management Portal is a secure, free tool used to manage Provider enrollment and credentialing requests. All credentialing requests for a Provider to join the network must be submitted electronically through the portal.

Available functions include:

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

Access

Office managers, administrative personnel, or Providers who need access to the portal for the first time must submit a registration request directly through the Provider Network Management Portal at Molina/ProviderManagement.

Member rights and responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in Molina's Member materials (such as Member Handbook). For additional information please refer to the Member Rights and Responsibilities section of this Provider Manual.

Member information and marketing

Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all State and Federal Laws and regulations and must be approved by Molina prior to use. Please contact your Provider Relations 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 the 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.

Providers who contract with Molina may verify a Member's eligibility by checking the following:

- Availity Essentials portal at Availity.com/providers
- Molina Provider Services automated IVR system at (855) 237-6178

Member cost share

Providers should verify the Molina Member's cost share status prior to requiring the Member to pay coinsurance, deductible or other cost share that may be applicable to the Member's specific benefit plan. Some plans have a total maximum cost share that frees the Member from any further out-of-pocket charges once reached (during that calendar year).

Health care services (Utilization Management and Care Management)

Providers are required to participate in and comply with Molina's Utilization Management (UM) and Care Management programs, including all policies and procedures regarding Molina's facility admission, Prior Authorization, and Medical Necessity review determination and Interdisciplinary Care Team (ICT) procedures. Providers will also cooperate with Molina in audits to identify, confirm, and/or assess utilization levels of covered services.

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

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

Referrals

A referral may become necessary when a Provider determines medically necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals unless the situation is one involving the delivery of emergency services. Information is to be exchanged between the PCP and Specialist to

coordinate care of the patient to ensure continuity of care. Providers need to document referrals that are made in the patient's medical record. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

Providers should direct Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed (if applicable) with Molina. In the case of urgent and Emergency Services, Providers may direct Members to an appropriate service including, but not limited to, primary care, urgent care and hospital emergency room. There may be circumstances in which referrals may require an out of network Provider; Prior Authorization will be required from Molina except in the case of emergency services. PCPs are able to refer a Member to an in-network specialist for consultation and treatment without a Prior Authorization.

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

PCPs are able to refer a Member to an in-network specialist for consultation and treatment without a referral request to Molina.

Treatment alternatives and communication with members

Molina endorses open Provider-Member communication regarding appropriate treatment alternatives and any follow up care. Molina promotes open discussion between Provider and Members regarding medically necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate 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 benefit

Providers are required to adhere to Molina's Comprehensive Drug List and prescription policies. You can find a list at MolinaMeds.com/SC. For additional information please refer to the Pharmacy section of this Provider Manual.

Participation in quality programs

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

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

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

Compliance

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

Confidentiality of member health information and HIPAA transactions

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

Participation in grievance and appeals programs

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

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

Participation in credentialing

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

For more information on Molina's credentialing program, please refer to the Credentialing and Recredentialing section of this Provider Manual.

Delegation

Delegated entities must comply with the terms and conditions outlined in Molina's Delegated Services Addendum. For additional information on Molina's delegation requirements and delegation oversight, please refer to the Delegation section of this Provider Manual.

Primary care provider responsibilities

PCPs are responsible to:

- Serve as the ongoing source of primary and preventive care for Members
- Assist with coordination of care as appropriate for the Member's health care needs

- Recommend referrals to specialists participating with Molina
- Triage appropriately
- Notify Molina of Members who may benefit from Care Management
- Participate in the development of Care Management treatment plans

Screening, Brief Intervention and Referral to Treatment (SBIRT)

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

Relocations and additional sites

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

Section 6 Culturally and linguistically appropriate services

Background

Molina works to ensure all Members receive culturally and linguistically appropriate care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the U.S. Department of Health and Human Services (HHS), seek to improve the appropriateness and accessibility of health care services by meeting the cultural, linguistic and accessibility related needs of individuals served. Molina complies with Section 1557 of the Patient Protection and Affordable Care Act, prohibiting discrimination in health programs and activities receiving federal financial assistance on the basis of race, color, and national origin, sex, age, and disability per title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1975 (29 U.S.C. § 794). Molina complies with applicable portions of the Americans with Disabilities act of 1990. Molina also complies with all implementing regulations for the foregoing. 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, sexes, 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 culturally and linguistically appropriate services is available on the Availity Essentials portal (go to Payer spaces, Resources Tab), from local Molina Provider Relations representatives or by calling Molina Provider Services at (855) 237-6178.

Nondiscrimination in health care service delivery

Molina complies with Section 1557 of the ACA. As a Provider participating in Molina's Provider Network, you and your staff must also comply with the nondiscrimination provisions and guidance set forth by the Department of Health and Human Services, Office for Civil Rights (HHS-OCR); State law; and Federal program rules, including Section 1557 of the ACA.

You are required to do, at a minimum, the following:

1. You **MAY NOT** limit your practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.
2. You **MUST** post in a conspicuous location in your office, a Nondiscrimination Notice. A sample of the Nondiscrimination Notice that you will post can be found in the Member Handbook located at MolinaHealthcare.com/members/sc/en-US/mem/medicaid/overvw/handbook.aspx.

3 You **MUST** post in a conspicuous location in your office, a Tagline Document, that explains how to access non-English language services at no cost. A sample of the Tagline Document that you will post can be found in the Member Handbook located at MolinaHealthcare.com/members/sc/en-US/mem/medicaid/overvw/handbook.aspx.

4 If a Molina Member is in need of accessibility-related services, you **MUST** provide reasonable accommodations for individuals with disabilities and appropriate auxiliary aids and services.

5 If a Molina Member is in need of language assistance services while at your office, and you are a recipient of Federal Financial Assistance, you **MUST** take reasonable steps to make your services accessible to persons with limited English proficiency ("LEP"). You can find resources on meeting your LEP obligations at Limited English Proficiency (LEP) | HHS.gov and Limited English Proficiency Resources for Effective Communication | HHS.gov.

6 If a Molina Member complains of discrimination, you **MUST** provide them with the following information so that they may file a complaint with Molina's Civil Rights Coordinator or the HHS-OCR:

Civil Rights Coordinator
Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802
Phone (866) 606-3889
TTY/TDD: 711
Email: civil.rights@MolinaHealthcare.com

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Website: ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Complaint Form: hhs.gov/ocr/complaints/index.html

If you or a Molina Member needs additional help or more information, call the Office of Civil Rights at (800) 368-1019 or TTY/TDD: (800) 537-7697 for persons with hearing impairments.

Culturally and linguistically appropriate practices

Molina is committed to reducing health care disparities and improving health outcomes for all Members. Training employees, Providers and their staffs, and improving appropriateness and accessibility are the cornerstones of assessing, respecting and responding to a wide variety of cultural, linguistic and accessibility needs when providing health care services. Molina integrates culturally and linguistically appropriate practices training into the overall Provider training

and quality-monitoring programs. An integrated quality approach enhances the way people think about our Members, service delivery and program development so that culturally and linguistically appropriate practices become a part of everyday thinking.

Provider and community training

Molina offers educational opportunities in culturally and linguistically appropriate practices and concepts for Providers and their staff. Molina conducts Provider training during Provider orientation with annual reinforcement training offered through Provider Services and/or online/web-based training modules. Web-based training modules can be found on the Availity Essentials portal.

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

1. Provider written communications and resource materials
2. On-site culturally and linguistically appropriate practices training
3. Online culturally and linguistically appropriate practices Provider training
4. Integration of culturally and linguistically appropriate practices and concepts and nondiscrimination of service delivery into Provider communications

Integrated quality improvement

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

Molina develops Member materials according to Plain Language Guidelines. Members or Providers may also request written Member materials in alternate languages and formats (i.e., braille, audio, large print), leading to better communication, understanding and Member satisfaction. Online materials found on MolinaHealthcare.com and information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.

Key member information, including appeal and grievance forms, is also available in threshold languages on the Molina Member website.

Access to language services

Providers may request interpreters for Members who speak a language other than English, including ASL, by calling Molina's Member Services at (855) 882-3901 (TTY: 711). If Molina Member Services representatives are unable to interpret in the requested language, the representative will immediately connect you and the Member to a qualified interpreter.

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

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

All eligible Members with Limited English Proficiency (LEP) are entitled to receive language services. Pursuant to Title VI of the Civil Rights Act of 1964, services provided for Members with LEP, limited reading proficiency, or limited hearing or sight are the financial responsibility of the Provider. Under no circumstances are Molina Members responsible for the cost of such services. Written procedures are to be maintained by each office or facility regarding their process for obtaining such services. Molina is available to assist providers with locating these services if needed.

An individual with LEP is an individual whose primary language for communication is not English and who has a limited ability to read, write, speak or understand English well enough to understand and communicate effectively (whether because of language, cognitive or physical limitations). It is possible that an individual with LEP may be able to speak or understand English but still be limited to read or write in English. It is also important to not assume that an individual who speaks some English is proficient in the technical vocabulary of the health care services required.

Molina Members are entitled to:

- Be provided with effective communications with medical Providers as established by the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and the Civil Rights Act of 1964.
- Be given access to Care Managers trained to work with individuals with cognitive impairments.
- Be notified by the medical Provider that interpreter services, including ASL, are available at no cost
- Be given reasonable accommodations, appropriate auxiliary aids and services
- Decide, with the medical Provider, to use an interpreter and receive unbiased interpretation.
- Be assured of confidentiality, as follows:
    - Interpreters must adhere to Health and Human Service Commission (HHSC) policies and procedures regarding confidentiality of Member records.
    - Interpreters may, with Member written consent, share information from the Member's records only with appropriate medical professionals and agencies working on the Member's behalf.
    - Interpreters must ensure that this shared information is similarly safeguarded.
- Have interpreters, if needed, during appointments with the Member's Providers and when talking to the health plan.

Interpreters include people who can speak the Member's primary language, assist with a disability or help the Member understand the information.

When Molina Members need an interpreter, limited hearing and/or limited reading services for health care services, the Provider should:

- Verify the Member's eligibility and medical benefits.
- Inform the Member that an interpreter, limited hearing, and/or limited reading services are available.
- Molina is available to assist Providers with locating these services if needed:
    - Providers needing assistance finding on-site, video remote, or telephonic interpreter services.
    - Providers needing assistance obtaining written materials in preferred languages.
    - Providers with Members who cannot hear or have limited hearing ability may use the National TTY/TDD Relay service at 711.
    - Providers with Members with limited vision may contact Molina for documents in large print, braille or audio version.
    - Providers with Members with limited reading proficiency.
    - The Molina Member Services representative will verbally explain the information, up to and including reading the documentation to the Members or offer the documents in audio version.

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

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

Molina strongly recommends that Provider offices make assistive listening devices available for Members who are deaf or 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 on-site or video service delivery for ASL to support our Members who are deaf or hard of hearing. Requests should be made at least 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 the Molina Member Services.

24-hour Nurse Advice Line

Molina provides nurse advice services for Members 24 hours a day, 7 days a week. The Nurse Advice Line provides access to 24-hour interpretive services. Members may call Molina's Nurse Advice Line directly - (844) 800-5155 (TTY: 711). The Nurse Advice Line telephone numbers are also printed on Molina Member ID cards.

Program and policy review guidelines

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

- Annual collection and analysis of race, ethnicity and language data from:
- Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's membership.
- Contracted Providers to assess gaps in network demographics.
- 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 and cultural responsiveness.
- Collection of data and reporting for the Language Description 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 across the Plan's subpopulations.
- Analysis of HEDIS® and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Section 7 Health Care Services (HCS)

Introduction

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

Inpatient authorization request: An inpatient authorization request consists of notification of admission and submission of clinical documentation supporting members condition and level of care for Molina to render a decision.

Utilization Management (UM)

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

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

Key functions of the UM program

All Prior Authorizations are based on a specific standardized list of services. The key functions of the UM program are listed below:

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

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

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

UM decisions

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

- Determination to authorize, provide or pay for services (favorable determination);
- Determination to delay, modify, or deny authorization or payment of request (adverse determination);

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 reviewers from appropriate specialty areas are utilized to assist in making determinations of medical necessity, as appropriate. All utilization determinations are made in a timely manner to accommodate the clinical urgency of the situation, in accordance with Federal and State regulatory requirements and NCQA standards.

Requests for authorization not meeting medical necessity criteria are reviewed by a designated Molina Medical Director or Health Care Professional who has appropriate clinical expertise in treating the Medicaid Managed Care Member's condition or disease.

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

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

Medical necessity

Medically Necessary or Medical Necessity is defined as services utilized in the State Medicaid Program, including quantitative and non-quantitative treatment limits, to determine the level of need for medical services rendered, as indicated in State statutes and regulations, the State Plan, and other State policy and Procedures.

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

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

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

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

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

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

MCG Cite for guideline transparency and MCG Cite AutoAuth

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

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

MCG Cite for Guideline Transparency does not affect the process for notifying Molina of admissions or for seeking Prior Authorization approval. To learn more about MCG or Cite for Guideline Transparency, visit MCG's website or call (888) 464-4746.

Molina has also partnered with MCG Health, to extend our Cite AutoAuth self-service method for all lines of business to submit advanced imaging prior authorization (PA) requests.

Cite AutoAuth can be accessed via the Availity Essentials portal and is available 24 hours per day/7 days per week. This method of submission is the primary submission route. Molina will also be rolling out additional services throughout the year. Clinical information submitted with the PA will be reviewed by Molina. This system will provide quicker and more efficient processing of your authorization request, and the status of the authorization will be available immediately upon completion of your submission.

What is Cite Autoauth and how does it work?

By attaching the relevant care guideline content to each PA request and sending it directly to Molina, health care providers receive an expedited, often immediate, response. Through a customized rules engine, Cite AutoAuth compares Molina's specific criteria to the clinical information and attached guideline content to the procedure to determine potential for auto authorization.

Self-services available in the Cite AutoAuth tool include, but are not limited to, MRIs, CTs, PET scans. To see the full list of imaging codes that require PA, refer to the PA code Look-Up Tool at MolinaHealthcare.com.

Medical necessity review

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

Levels of administrative and clinical review

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

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

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

Clinical information

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

Prior authorization

Services that require prior authorization

Molina requires prior authorization for specified services as long as the requirement complies with federal or state regulations and the Provider Services Agreement with Molina. The list of services that require prior authorization is available in narrative form, along with a more detailed list by Current Procedural Terminology (CPT®) and Healthcare Common Procedural Coding System (HCPCS) codes. Molina Prior Authorization documents are customarily updated quarterly but may be updated more frequently as appropriate or required by the SCDHHS and are posted on the Molina website at MolinaHealthcare.com.

CPT® is a registered trademark of the American Medical Association.

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

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

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

- Requested length of stay (for inpatient requests).
- Rationale for expedited processing.

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

Molina follows all prior authorization requirements related to care for newborns and their mothers in alignment with the Newborns' and Mothers' Health Protection Act (NMHPA).

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

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

Timelines for UM decisions

Type of Request	Defined	Determination Timeline	Notification
Standard Prior Authorization Request	Elective services and procedures	Decision made and notification provided within 7 calendar days	Approvals, the Provider will receive an authorization number, by phone or fax. Denied services, the Provider will receive a faxed letter. Member will receive letter by mail. The letter will explain the reason for the denial and additional information regarding the grievance and appeals process.

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

Evolent

Molina collaborates with Evolent (formerly known as New Century Health) to conduct medical necessity review on certain prior authorization (PA) requests.

PA requests for Participating Servicing Providers are to be submitted to Evolent for professional service review and decisions for Molina adult Members ages 18 and over.

All out-of-network Servicing Provider PA requests and PA requests for Molina Members under the age of 18 will be reviewed by Molina.

Evolent conducts reviews for the following professional services:

Cardiology

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

Please consult the PA Lookup Tool for further guidance on where to submit professional services PA requests.

For inpatient service requests, once approved by Evolent, the inpatient status will be reviewed by Molina upon notification of the admission. The inpatient admission and length of stay will be determined by Inpatient Utilization Management (Concurrent Review) at the time of hospitalization. Providers are to follow Molina's inpatient notification process as you do today, and the continued stay will be reviewed for medical necessity and a decision made at that time.

Medical Oncology

Cancer Related Diagnoses: C00-D09.0, D37.01-D49.9, D61.810, D61.82, D63.0, D64.0-D64.81, D70.1, D72.822, D75.81, E34.0

Infused, injectable and oral* chemotherapy, hormonal therapeutic treatment, supportive agents, and symptom management medications.

Pharmacy benefit single oral agent requests are out of scope for Evolent and pre-authorization must be obtained from Molina or applicable Pharmacy Benefits Manager (PBM). For Marketplace Members, Pharmacy benefits oral agents submitted in a request combined with infused/injectable cancer agents will be reviewed by Evolent for preauthorization.

Radiation Oncology

Cancer Related Diagnoses: C00-D09.0, D37.01-D49.9, D61.810, D61.82, D63.0, D64.0-D64.81, D70.1, D72.822, D75.81, E34.0

- Brachytherapy
- Conformal
- IMRT (Intensity-modulated radiation therapy)
- SBRT (Stereotactic Body Radiation Therapy)
- IGRT (Image-guided radiation therapy)
- 2D, 3D (2 or 3 dimensional)
- SRS (Stereotactic radiosurgery)
- Radiopharmaceuticals
    - Proton and Neutron Beam Therapy

CAR-T

For inpatient CAR-T service requests, the inpatient status will be approved when medical necessity criteria is met, simultaneously with the approval of the CAR-T professional service(s) being reviewed.

The inpatient admission length of stay (where CAR-T is in scope) will be determined by Inpatient Utilization Management (Concurrent Review) at the time of any needed hospitalization. Providers are to follow Molina's inpatient notification process as you do today, and the continued stay will be reviewed for medical necessity and a decision made at that time. If other services are being

performed during the inpatient stay that are unrelated to the CAR-T procedures, a separate authorization will need to be completed through Molina's standard prior authorization process for medical necessity determination.

PA request submission

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

For Providers' convenience, logging into the Evolent Provider Web Portal is the preferred submission method: my.newcenturyhealth.com

- Evolent's Provider Web Portal functionality offers instant approvals for PA requests
- Evolent Tel: (888) 999-7713
- Evolent Fax intake:
    - Cardiology: (877) 370-0963
    - Medical Oncology: (877) 230-4493
    - Radiation Oncology: (877) 380-7848

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

Evolent: Retro-authorization

All retro-authorization* and extenuating circumstances reviews should be sent to Molina following the process you use today. The 30-day authorization reconsideration process excludes all the above-listed cardiology professional services based on our partnership with Evolent.

For cardiology, Providers can submit same-day diagnostic and procedure authorization requests up to 10 business days from the date of service (DOS)/treatment start date (TSD). Procedure must meet medical necessity criteria.

Peer-to-peer review

Upon receipt of an adverse determination, the Provider (peer) may request a peer-to-peer discussion within five (5) business days from the notification.

A "peer" is considered the Member's or Provider's clinical representative (licensed medical professional). Contracted external parties, administrators, or facility UM staff can only request that a peer-to-peer telephone communication be arranged and performed, but the discussion should be performed by a peer.

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

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

If a Medical Director is not immediately available, the call will be returned within two (2) business days. Every effort will be made to return calls as expeditiously as possible.

Evolent: peer-to-peer review

Peer-to-peer review will be conducted by Evolent via physician discussions with expanded collaboration to better discuss treatment plans.

Providers are strongly encouraged to take advantage of Evolent's streamlined peer-to-peer process to hold timely conversations related to requested services.

Requesting prior authorization

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

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

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

Availity Essentials portal: Molina is a Digital First organization for authorization submissions and phone or fax-based submissions may not be available in certain markets. Participating Providers should use the Availity Essentials portal for prior authorization submissions. All prior authorization submissions must include supporting clinical documentation to ensure timely and accurate review. Instructions for how to submit a prior authorization request are available on the Availity Essentials portal. The benefits of submitting your prior authorization request through the Availity Essentials portal are:

- Create and submit a Prior Authorization Request electronically.
- Check status of an Authorization Request.
- Receive notification of change in status of an Authorization Request.
- Attach medical documentation required for timely medical review and decision making.
- Receive notification of authorization decisions
- Access prior authorization letters directly through the Digital Correspondence Hub functionality in the Availity Essentials portal. Please note: Letters will only be available for prior authorization requests submitted via the Availity Essentials portal.

Digital Correspondence Hub

The Digital Correspondence Hub lets your organization manage communication preferences in the Availity Essentials portal. Only your designated Administrator can change settings, including opting out of paper letters. For updates, please contact your Administrator.

Users can also choose to receive or decline weekly reminder notifications for unopened digital letters. These reminders are not realtime alerts. Opting out of reminders does not affect your organization's digital correspondence delivery preferences.

Evolent

Molina collaborates with Evolent (formerly known as New Century Health) to conduct medical necessity review on certain prior authorization (PA) requests.

PA requests for Participating Servicing Providers are to be submitted to Evolent for professional service review and decisions for Molina adult Members ages 18 and over.

All out-of-network Servicing Provider PA requests and PA requests for Molina Members under the age of 18 will be reviewed by Molina.

Evolent conducts reviews for the following professional services:

Cardiology

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

Please consult the PA Lookup Tool for further guidance on where to submit professional services PA requests.

For inpatient service requests, once approved by Evolent, the inpatient status will be reviewed by Molina upon notification of the admission. The inpatient admission and length of stay will be determined by Inpatient Utilization Management (Concurrent Review) at the time of hospitalization. Providers are to follow Molina's inpatient notification process as you do today, and the continued stay will be reviewed for medical necessity and a decision made at that time.

Medical Oncology

Cancer Related Diagnoses: C00-D09.0, D37.01-D49.9, D61.810, D61.82, D63.0, D64.0-D64.81, D70.1, D72.822, D75.81, E34.0

Infused, injectable and oral* chemotherapy, hormonal therapeutic treatment, supportive agents, and symptom management medications.

Pharmacy benefit single oral agent requests are out of scope for Evolent and pre-authorization must be obtained from Molina or applicable Pharmacy Benefits Manager (PBM). For Marketplace Members, Pharmacy benefits oral agents submitted in a request combined with infused/injectable cancer agents will be reviewed by Evolent for preauthorization.

Radiation Oncology

Cancer Related Diagnoses: C00-D09.0, D37.01-D49.9, D61.810, D61.82, D63.0, D64.0-D64.81, D70.1, D72.822, D75.81, E34.0

- Brachytherapy
- Conformal
- IMRT (Intensity-modulated radiation therapy)
- SBRT (Stereotactic Body Radiation Therapy)
- IGRT (Image-guided radiation therapy)
- 2D, 3D (2 or 3 dimensional)
- SRS (Stereotactic radiosurgery)
- Radiopharmaceuticals
    - Proton and Neutron Beam Therapy

Evolent: peer-to-peer review

Peer-to-peer review will be conducted by Evolent via physician discussions with expanded collaboration to better discuss treatment plans.

Providers are strongly encouraged to take advantage of Evolent's streamlined peer-to-peer process to hold timely conversations related to requested services.

ProgenyHealth: NICU Admission and Concurrent Review

Molina collaborates with ProgenyHealth for neonatal care management services provided to premature and medically complex newborns in the Neonatal Intensive Care Unit (NICU).

All NICU utilization management functions including initial admissions, continued stay requests, discharge planning, and all readmissions up to 60 days post-discharge of the initial NICU discharge will be managed by ProgenyHealth. Providers must submit NICU authorization equests and clinical documentation supporting the NICU stay to ProgenyHealth directly.

- Phone: (888) 832-2006
- UM Email: MolinaMarketplaceUM@progenyhealth.com
- CM Email: MolinaMarketplaceCM@progenyhealth.com
- Website: ProgenyHealth.com

For all infants born and/or admitted to the NICU, NICU Notification of Admission must be faxed directly to ProgenyHealth at (888) 250-8468. The following information must be included:

- Mother's Name, Date of Birth, Member ID number
- Infant Name (if known) and Member ID number (if known)
- Attending Physician NPI number
- Facility NPI number

ProgenyHealth: Peer-to-peer review

- Peer-to-peer may be requested with a ProgenyHealth Medical Director by calling (888) 832-2006 and following the Physician Advisor's prompt and directions.
- If peer-to-peer is declined or if the denial determination is upheld, providers would follow Molina's appeal process if not in agreement with the determination.

ProgenyHealth: Transfers and readmissions

- ProgenyHealth will manage infants transferred from the NICU to another acute care facility under the guidance of Molina's current rules for higher, lateral, and lower-level care transfers.
- ProgenyHealth will manage emergent readmissions for all infants managed by ProgenyHealth for their initial NICU admission if readmitted within the first 60 days after the initial NICU discharge date.

ProgenyHealth: Utilization Management Cases

- All concurrent stay reviews and discharge summaries should be faxed directly to ProgenyHealth.

ProgenyHealth: Care Management Program Review

- Families will have a dedicated Case Manager who will provide support and education.
- Following notification of NICU admission, ProgenyHealth outreaches caregivers for early inpatient engagement to evaluate Social Determinants of Health and barriers to safe discharge home.
- ProgenyHealth Case Managers will continue to follow Molina Members for 60 days from the initial NICU discharge date.
- ProgenyHealth Case Managers, Social Workers, and Care Coordinators assist Molina Members with identifying support and utilizing national and local community resources.
    - Identifying PCP
    - Behavioral health support
    - Lactation services/obtaining a breast pump
    - Transportation resources

ProgenyHealth will collaborate with facility CM for infants with anticipated discharge needs, complex medical care, or considerable social situations.

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 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

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

Providers should use the Availity Essentials portal for UM access.

Molina's Nurse Advice Line is available to Members 24 hours a day, 7 days a week at (844) 800-5155 (TTY: 711). Molina's Nurse Advice Line may handle after-hours UM calls.

Services and/or procedures that require prior authorization

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

Emergency Services

Emergency Services means covered inpatient and outpatient services that are

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

Emergency Medical Condition or Emergency means:

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

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

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

Post-stabilization care services are covered services that are:

1. Related to an emergency medical condition
2. Provided after the Member is stabilized
3. Provided to maintain the stabilized condition, or under certain circumstances, to improve or resolve the Member's condition

Requests for post stabilization services must be submitted by contacting Molina at (855) 237-6178.

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

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

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

Post stabilization services after emergency care

Post stabilization care services are covered services, whether inside or outside Molina's service area, that are related to an Emergency Medical Condition and provided after a Member is stabilized in order to maintain the stabilized condition, or to improve or resolve the Member's condition until one of the following occurs:

A. The Member is discharged; or

B. A Molina participating physician with privileges at the treating hospital assumes responsibility for the Member's care; or

C. A Molina participating physician assumes responsibility for the Member's care through transfer; or

D. A Molina medical director and the treating physician reach an agreement concerning the Member's care.

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

Inpatient management

Planned admissions

Molina requires Prior Authorization for all elective inpatient procedures to any facility. Facilities are required to notify Molina within **twenty-four (24) hours or by the following business day** once an 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 authorization for all inpatient admissions, including emergent admissions. Notification of all emergent inpatient admissions must be received 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 admission notification, medical necessity requirements or failure to include all of the needed clinical documentation to support the need for an inpatient admission may result in a denial of authorization for the inpatient stay.

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

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

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

Observation stay converted to inpatient admission

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

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

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

Molina requires authorization for all inpatient admissions, including emergent admissions and those converted from observation to inpatient level of care. Providers must submit an inpatient authorization request with clinical documentation supporting members condition and level of care within **twenty-four (24) hours** when the level of care status has changed from Observation to Inpatient admission or by the following business day for Molina to render a decision.

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

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

Inpatient at time of termination of coverage

When a Member's coverage with Molina terminates during a hospital stay, Molina will continue to cover services through discharge unless law or program requirements mandate otherwise.

Inpatient/concurrent review

Molina performs concurrent inpatient review in order to ensure patient safety, medical necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. We have streamlined the process by increasing the time frame between admission and the next concurrent review date. Additionally, we only request current clinical information instead of daily notes. This will allow greater focus on monitoring patient progress and assisting with discharge planning. Performing these functions requires timely clinical information updates from inpatient facilities. Molina will request updated clinical records from inpatient facilities at regular intervals during a Member's inpatient stay.

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

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

Inpatient status determinations

Molina's UM staff follow federal and state guidelines along with evidence-based criteria to determine if the collected clinical information for requested services are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member" by meeting all coverage, coding and medical necessity requirements.

Discharge planning

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

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

Nursing facility admissions

Level of Care Determination Form 185 is required under SCDHHS fee-for-service Medicaid when submitting a request for nursing facility admissions. Do not submit Molina PA requests for long-term NF stays. Follow SCDHHS processes.

Readmissions

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

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

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

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

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

- A Readmission is considered potentially preventable if it is clinically related to the prior admission and includes, but not limited to, the following circumstances:
    - 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.
    - The subsequent admission was due to a hospital acquired condition.

Post service review

Failure to obtain authorization when required may 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. In those cases, a medical necessity review will be performed. Decisions, in this circumstance, will be based on medical necessity.

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 practitioners and licensed staff unhindered by fiscal or administrative concerns. Molina and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to Members.

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

Out of network providers and services

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

Avoiding conflict of interest

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

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

Coordination of care and services

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

of care process assists Molina Members, as necessary, in transitioning to other care when benefits end.

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

Continuity of care and transition of members

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

- Acute condition or serious chronic condition – Following termination, the terminated Provider will continue to provide covered services to the Member up to 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 of pregnancy – The terminated Provider will continue to provide services following termination until postpartum services related to delivery are completed or longer, if necessary, for a safe transfer.

For each Member identified in the categories above, Molina will work with the treating Provider on a transition plan over a reasonable period of time. Each case will be individualized to meet the Member's needs.

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

- The Member only requires monitoring of a chronic condition
- The Provider does not qualify for Molina credentialing based on a previous professional review action
- The Provider is unwilling to continue care for the Member
- The Provider has never seen the Member prior to enrolling with Molina

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

Continuity and coordination of provider communication

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

Reporting of suspected abuse and/or neglect

A vulnerable adult is a person who is receiving or may be in need of receiving community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of themself, or unable to protect themself 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 childcare givers
- Psychologists, social workers, family protection workers, or family protection specialists
- Attorneys, ministers, or law enforcement officers.

Suspected abuse and/or neglect should be reported to the South Carolina Department of Social Services at (888) CARE4US or (888) 227-3487, 24 hours a day/7 days a week.

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

Client Services phone number (800) 616-1309.

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

Adult abuse:

When there is concern that a Member is being abused, Molina's HCS teams will communicate with PCPs, Medical Groups/IPA, and delegated entities that one of your patients may be in this possible situation. All physicians, healthcare professionals, delegated entities, as well as Molina have a mandatory requirement, by law, to notify regulatory entities when adult and child abuse is suspected. Final actions are taken by the PCP/Medical Group/IPA, other delegated entities or other clinical personnel. Under State and Federal Law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation or self-neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

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

PCP responsibilities in care management referrals

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

Care manager responsibilities

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

- Assesses the Member to determine if the Member's needs warrant care management.
- Monitors and communicates the progress of the implemented ICP to the Member's ICT, as the Member's needs warrant.
- Serves as a coordinator and resource to the Member, their representative, and ICT participants, throughout the implementation of the ICP, and revises the plan as suggested and needed.
- Coordinates appropriate education and encourages the Member's role in self-management.
- Monitors progress toward the Member's achievement of ICP goals in order to determine an appropriate time for the Member's graduation from the ICM program.

Health Management

The tools and services described here are educational support for Molina Members and may be changed at any time as necessary to meet the needs of Molina Members. Level one Members can be engaged in the program for up to ninety (90) days depending on Member preferences and the clinical judgment of the Health Management team.

Level 1 case management (health management)

Molina offers programs to help our Members and their families manage various health conditions. The programs include telephonic outreach from our clinical staff and health educators that includes condition specific triage assessment, care plan development and access to tailored

educational materials. Members are identified via Health Risk assessments and identification and stratification, along with access to educational materials. You can also directly refer Members who may benefit from these program offerings by calling Molina's Provider Services department at (855) 237-6178 and selecting the option for "care management". Our Care Manager will help refer your patient to our Health Management team. Members can request to be enrolled or disenrolled in these programs at any time.

The chronic conditions programs include:

- Asthma
- Depression
- Diabetes
- COPD
- Heart Failure
- Hypertension

Molina healthy lifestyle programs include:

- Weight Management
- Tobacco Cessation
- Nutrition consult

For more information about these programs, please call (833) 269-7830 (main line) or (866) 472-9483 (healthy lifestyle programs), TTY/TDD: 711 or fax at (800) 642-3691.

Maternity screening and high risk obstetrics

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

Member health education materials

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

Program eligibility criteria and referral source

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

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

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

Provider participation

Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease
- Clinical resources such as patient assessment forms and diagnostic tools
- Patient education resources
- Provider Newsletters promoting the Health Management Programs, including how to enroll patients and outcomes of the programs
- Clinical Practice Guidelines; and
- Preventive Health Guidelines
- Case Management collaboration with the Member's Provider
- Faxing a Provider Collaboration Form to the Member's Provider when indicated

Additional information on Health Management Programs is available from your local Molina Healthcare Services department.

Primary Care Providers

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

Specialty providers

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

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

Care Management (CM)

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

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

Referral to care management

Members with high-risk medical conditions and/or other care needs may be referred by their PCP or specialty care Provider, themselves, caregiver, discharge planner or Molina Healthcare Services to the CM program. The care manager works collaboratively with the Member and all participants of the ICT when warranted, including the PCP and specialty Providers, ancillary Providers, the local Health Department or other community-based resources when identified.

The referral source should be prepared to provide the care manager with demographic, health care and social data about the Member being referred.

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

- High-risk pregnancy, including Members with a history of a previous preterm delivery
- Catastrophic or end-stage medical conditions (e.g., neoplasm, organ/tissue transplants)
- Comorbid chronic illnesses (e.g., asthma, diabetes, COPD, CHF, etc.)
- Preterm births
- High-technology home care requiring more than two weeks of treatment
- Member accessing emergency department services inappropriately
- Children with Special Health Care Needs
- Sickle Cell
- Members with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD)

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

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

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

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

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

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

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

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

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

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

Section 8 Behavioral Health

Overview

Molina provides a behavioral health benefit for Members. Molina takes an integrated, collaborative approach to behavioral health care, encouraging participation from PCPs, behavioral health, and other specialty Providers to ensure whole-person care. Molina complies with the most current Mental Health Parity and Addiction Equity Act requirements. All provisions within the Provider Manual are applicable to medical and behavioral health Providers unless otherwise noted in this section.

Utilization management and prior authorization

For additional information please refer to the **Prior Authorization** subsection found in the **Health Care Services** section of this Provider Manual.

Some behavioral health services may require prior authorization.

Behavioral health inpatient, substance use disorder residential services, psychiatric residential treatment, and select outpatient treatment(s) can be requested by submitting a Prior Authorization form or contacting Molina's prior authorization team at (855) 237-6178. Molina strongly recommends the use of he Availity portal to submit ALL prior auth requests.

Emergency psychiatric services do not require prior authorization. All requests for behavioral health services should include the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification as well as current clinical information supporting the request. Molina utilizes standard, generally accepted medical necessity criteria for prior authorization reviews.

The most current prior authorization guidelines and the Prior Authorization Request Form can be found on the Molina website at MolinaHealthcare.com.

Access to behavioral health providers and PCPs

Members may be referred to an in-network behavioral health Provider via referral from a PCP, medical specialist, or by Member self-referral. PCPs are able to screen and assess Members for the detection and treatment of any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate behavioral health service within the scope of their practice and in compliance with all state and regulatory requirements for the service provision. A formal referral form or prior authorization is not needed for a Member to self-refer or be referred to a PCP, specialist, or behavioral health Provider. However, individual services provided by non-network behavioral health providers will require prior authorization.

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

Substance use disorder assessment and placement

Members receiving substance use disorder services must be assessed using the American Society of Addiction Medicine (ASAM) Criteria. Providers are responsible for determining the Member's severity level in accordance with ASAM Criteria and recommending placement in the appropriate level of care. Ongoing reassessment should occur as clinically indicated to ensure the Member continues to receive services at the appropriate level of care.

Care coordination and continuity of care

Discharge planning

Discharge planning begins upon admission to an inpatient or residential behavioral health facility. Members who were admitted to an inpatient or residential behavioral health setting must have an adequate outpatient follow-up appointment scheduled with a behavioral health Provider prior to discharge and to occur within seven (7) days of the discharge date.

Interdisciplinary care coordination

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

Care management

Molina's care management team includes licensed nurses and clinicians with behavioral health experience to support Members with mental health and/or substance use disorder (SUD) needs. Members with high-risk psychiatric, medical or psychosocial needs may be referred by a behavioral health professional or primary care provider to the care management program.

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

Phone: (855) 237-6178

For additional information on the care management program, please refer to the Care Management subsection found in the **Health Care Services** section of this Provider Manual.

Behavioral Health Care Management

Access to Records and Information to Support Member Care Coordination and Care Management Activities

Molina is committed to working with its Providers to address the care coordination and care management needs of its members. To facilitate such activities, all Providers (including substance use disorder providers and behavioral health providers) are required to cooperate with and provide

to Molina any and all relevant patient/member records and information requested by Molina to support such activities. To the extent a consent and/or authorization from the patient/member is required by law to disclose the requested records/information to Molina, the Provider shall make best efforts to obtain the necessary consent(s) and/or authorization(s) from the patient/member.

Both Molina and the Provider agree to comply with HIPAA and other applicable federal and state privacy laws and regulations including, but not limited to, the HIPAA privacy regulations set forth in 45 C.F.R. Part 164 Subpart E, the HIPAA security regulations set forth in 45 C.F.R. Part 164 Subpart C, 42 C.F.R. Part 2 Regulations governing the Confidentiality of Substance Use Disorder Patient Records and state-specific medical privacy laws.

Responsibilities of behavioral health providers

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

Providers shall follow quality standards related to access. Molina provides oversight of Providers to ensure Members can obtain needed health services within acceptable appointment timeframes. Please refer to the **Quality** section of this Provider Manual for specific access to appointment details.

All Members receiving inpatient psychiatric services must be scheduled for a psychiatric outpatient appointment prior to discharge. The aftercare outpatient appointment must include the specific time, date, location, and name of the Provider. This appointment must occur within seven (7) days of the discharge date. If a Member misses a behavioral health appointment, the behavioral health Provider shall contact the Member within 24 hours of a missed appointment to reschedule.

Behavioral Health Crisis Line

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

National Suicide Lifeline

988 is the National Suicide Lifeline. Anyone in need of suicide or mental health crisis support or anyone with concerns about someone else, can receive free and confidential support 24 hours a day, 7 days a week, 365 days per year, by dialing 988 from any phone.

Behavioral health tool kit for providers

Molina has developed an online Behavioral Health Tool Kit to provide support with screening, assessment, and diagnosis of common behavioral health conditions, plus access to behavioral health Healthcare Effectiveness Data and Information Set (HEDIS®) tip sheets and other evidence-based guidance, training opportunities for Providers, and recommendations for coordinating care. The material within this tool kit is applicable to Providers in both medical and behavioral health settings. The Behavioral Health Tool Kit for Providers can be found under the "Health Resources" tab on the MolinaHealthcare.com Provider website.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Section 9 Medical management

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

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

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

Referral versus prior authorization

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

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

Surgical procedures

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

How to submit an authorization request

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

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

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

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

Emergency care

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

Members accessing the emergency department inappropriately will be contacted by Molina care managers whenever possible to determine the reason for using emergency services. Care managers will also contact the PCP to ensure that Members are not accessing the emergency department because of an inability to be seen by the PCP.

Prior authorization decision time frames

Pursuant to South Carolina state-established time frames, Molina will process any non-urgent Prior Authorization requests no later than 7 calendar days following receipt of the request for service. Urgent requests will be processed as expeditiously as possible and within 72 hours of receipt of the request for service. A Molina Member can request up to 14 extra calendar days if he/she or the Provider needs to submit more information before Molina makes a decision. Molina can also request additional days if more information is needed to make a decision. Molina can extend standard decision timelines by up to 14 additional calendar days if requested by the Member, Provider, or authorized representative, or if more information is needed for the Member's best interest. In urgent cases, Molina can expedite decisions when delays could jeopardize the Member's health, deciding within 72 hours of the request. Molina may also extend this 72-hour period by another 14 calendar days if justified. Members will receive written notice if an extension is required.

Non-network providers and services - Molina maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process in order to provide medical care for Molina Members. Molina requires Members to receive medical care within the participating, contracted network of Providers. All care provided by non-contracted, non-network Providers must be prior authorized by Molina. Non-network Providers may provide emergent/urgent care and dialysis services for a Member who is temporarily outside the service area, without Prior Authorization or as otherwise required by federal or state laws or regulations.

Decision making process

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

Molina does not reward Providers or other individuals for issuing denials of coverage or care. Furthermore, Molina never provides financial incentives to encourage authorization decision makers to make determinations that result in under-utilization. Also, we require our delegated medical groups/IPAs to agree to the same process.

Section 10 Pharmacy

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

Pharmacy and Therapeutics Committee

The National Pharmacy and Therapeutics Committee (P&T) meets quarterly to review and recommend medications for Comprehensive Drug List 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.

Federal regulations [42 C.F.R. § 456.703 - 456.725] require that Medicaid pharmacy programs establish and maintain a Drug Utilization Review (DUR) program that helps to ensure appropriate drug utilization by conducting prospective and retrospective drug utilization review and maintaining an educational program. The Molina Drug Utilization Review (DUR) board is organized to enhance and complement activities mandated to state Medicaid programs and act as an advisory board to Molina National P&T for all drug utilization program activities. Drug utilization review program activities help to ensure that prescriptions for outpatient drugs are appropriate, medically necessary, and not likely to result in adverse medical consequences. DUR activities use professional medical protocols and computer technology and data processing to assist in the management of data regarding the prescribing of medicines and the dispensing of prescriptions over periods of time.

Pharmacy network

Members must use their Molina ID card to get prescriptions filled. Molina's network includes, retail, mail, long term care and specialty pharmacies. Additional information regarding the pharmacy benefits, limitations, and network pharmacies is available by visiting MolinaHealthcare.com or calling Molina at (855) 882-3901 (TTY: 711).

Drug list

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

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

Covered medications on Comprehensive Drug List

Medication requiring PA may require the use of first-line medications before they are approved. Information on procedures to obtain these medications is described within this document and is also available on the Molina website at MolinaHealthcare.com.

Quantity limitations

In some cases, Members may only be able to receive certain quantities of medication. Information on specific limits can be found in the Comprehensive Drug List document. Quantity limitations have been placed on certain medications to ensure safe and appropriate use of the medication.

Age limits

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

Step therapy

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

Drugs not listed on the CDL

Medications not listed on the CDL may be considered for exception when listed medications are not appropriate for a particular Member or have been proven ineffective. Requests for CDL exceptions should be submitted using a PA form which is available on the Molina website at MolinaHealthcare.com. Clinical evidence must be provided and is taken into account when evaluating the request to determine medical necessity. The use of a manufacturer's samples of Non-Listed or "Prior Authorization Required" medications does not override CDL requirements.

Generic substitution

Generic drugs should be dispensed when preferred. If the use of a particular brand name non-covered drug 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 CDL during their first six months on the market. During this period, access to these medications will be considered through the PA process.

Medications not covered

There are some medications that are excluded from coverage. For example, drugs used in the treatment of infertility or those used for cosmetic purposes may not be part of the benefit. Specific exclusions can be found in the Comprehensive Drug List at MolinaHealthcare.com.

Submitting a prior authorization request

Molina's vendor, CVS Caremark, will only process completed prior authorization request forms. The following information MUST be included for the request form to be considered complete.

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

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

Electronic prior authorization (ePA): SureScripts® and CoverMyMeds

CVS Caremark's decisions are based upon the information included with the prior authorization request. Clinical notes are recommended. If clinical information and/or medical justification is missing, CVS Caremark will either respond via the electronic prior authorization (**ePA**) portal, 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 prior authorization form in its entirety, including medical justification and/or supporting clinical notes.

CVS Caremark utilizes PA portal submissions through the SureScripts® and CoverMyMeds® platforms that are integrated into physician office electronic health record (EHR) systems. The **ePA** portal automates the prior authorization process, making it a quick and simple way to complete prior authorization requests. The **ePA** portal process is HIPAA compliant and can enable faster coverage determinations. For select drugs and plans, CoverMyMeds® may issue immediate approval of your request and update your patient's prior authorization record to allow immediate claim adjudication.

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

Emergency Protocols for Continuity of Care

In the event of a disaster, the following emergency protocols will be activated to ensure continuity of care for our members:

1. Bypass Protocols: Pharmacies are enabled to bypass early refill, prior authorization (PA), and non-formulary edits for a 72-hour emergency period without requiring prior approval from us or CVS.
2. Authorization by Helpline: CVS and the member services helpline are authorized to approve medications on behalf of our health plan during emergencies.
3. Alternative Shipping: Specialty and mail-order programs will ship medications to alternative addresses to ensure members continue to receive essential care.

These protocols are crucial for maintaining members' access to necessary medications and services during emergencies.

Member and provider "patient safety notifications"

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

Specialty pharmaceuticals, injectable and infusion services

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

During the utilization management review process, Molina 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.

Molina may conduct a peer-to-peer discussion or other outreach to evaluate the level of care that is medically necessary. If an alternate site of care is suitable, Molina may offer the ordering Provider help in identifying an in-network infusion center, physician office or home infusion service and will help the Member coordinate and transition through case management.

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

Newly FDA approved medications must undergo review prior to being added to the CDL and will require a PA 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.

Molina completes utilization management for certain Healthcare Administered Drugs. Any drugs on the prior authorization list that use a temporary C code or other temporary HCPCS code that is not unique to a specific drug, which are later assigned a new HCPCS code, will still require prior authorization even after it has been assigned a new HCPCS code, until otherwise noted in the Prior Authorization list.

Pain Safety Initiative (PSI) resources

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

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

Site of Care

On 1/1/2021, Molina implemented a Site of Care policy for Medicaid and Marketplace that may change the place of service for certain medically necessary provider-administered medications (HCPCS J Codes). These medications must be rendered in the most appropriate setting, such as home or independent infusion centers (place of service 11 or 12), and not in a hospital setting unless it meets medically indicated exceptions. For the complete list and more information, including the medications and classes that this change will impact, visit MolinaHealthcare.com/-/media/Molina/PublicWebsite/PDF/Common/SC/All_LOB/Site_of_Care_Drug_List.pdf.

Section 11 Quality

Maintaining Quality Improvement processes and programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement program. You may contact the Molina Quality department 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 Relations representative or call the telephone number above to receive a written copy.

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

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

- Have a quality improvement program in place.
- Comply with and participate in Molina's Quality Improvement program, including reporting of access and availability survey and activity results and provision of medical records as part of the HEDIS® review process and during potential quality of care and/or critical incident investigations.
- Cooperate with Molina's quality improvement activities that are designed to improve quality of care and services and Member experience.
- Allow Molina to collect, use and evaluate data related to Provider performance for quality improvement activities, including but not limited to focus areas, such as clinical care, care coordination and management, service, and access and availability.
- Allow access to Molina QI personnel for site and medical record review processes.

Patient Safety Program

Molina's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Members in collaboration with their PCPs. Molina continues to support safe health practices for our Members through our safety program, pharmaceutical management and care management/health 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) and the Department of Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

Quality of care

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

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

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

Medical records

Molina requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member's medical record. Molina annually conducts a review of member's medical records from a representative sample of Primary Care Practitioners (PCP) of the Molina provider network against the medical record keeping standards and requirements as well as other providers as determined necessary. All entries will be indelibly added to the Member's record. PCPs should maintain the following medical record components, that include but are not limited to:

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

Medical record keeping practices

Below is a list of the minimum items that are necessary in the maintenance of the Member medical records:

- Each patient has a separate medical record.
- Medical records are stored away from patient areas and preferably locked.
- Medical records are available during each visit and archived records are available within twenty-four (24) hours.

- If hard copy, pages are securely attached in the medical record and records are organized by dividers or color-coded when the thickness of the record dictates.
- If electronic, all those with access have individual passwords, including privacy of confidential information, such as race, ethnicity, language, and sexual orientation and gender identity.
- Record keeping is monitored for quality and HIPAA compliance, including privacy of confidential information, such as race, ethnicity, language, and sexual orientation and gender identity.
- Storage maintenance for the determined timeline and disposal are managed per record management processes.
- Process is in place for archiving medical records and implementing improvement activities.
- Medical records are kept confidential and there is a process for release of medical records including behavioral health care records.

Practitioners/Providers must demonstrate compliance with Molina's medical record documentation guidelines. The provider is responsible to retain their records for at least ten (10) years for adult patients and at least thirteen (13) years for minors. Medical records are assessed based on the following standards:

Content

Providers must remain consistent in their practices with Molina's medical record documentation guidelines. Medical records are maintained and should include, but not be limited to the following information. All medical records should contain:

- The patient's name or ID number on each page in the record.
- The patient's name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact.
- Legible signatures and credentials of the Provider and other staff members within a paper chart.
- A list of all Providers who participate in the Member's care.
- Information about services that are delivered by these Providers.
- A problem list that describes the Member's medical and behavioral health conditions.
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Medication reconciliation within thirty (30) days of an inpatient discharge with evidence of current and discharge medication reconciliation and the date performed.
- Allergies and adverse reactions (or notation that none are known).

- Documentation that shows 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 recorded with the clinical findings.
- A working diagnosis that is recorded with the clinical findings.
- Pertinent history for the presenting problem.
- Pertinent physical exam for the presenting problem.
- Lab and other diagnostic tests that are ordered as appropriate by the Provider.
- Clear and thorough progress notes that state the intent for all ordered services and treatments.
- Notations regarding Follow-up care, calls or visits that include 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 as 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 and follow-up care, inpatient and outpatient care, including hospital discharge summaries, hospital history and physicals and operative report.
- Labor and delivery record for any child seen since birth.
- A signed document stating with whom protected health information may be shared.

Organization

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

Chart sections are easily recognized for retrieval of information.

- A release document for each Member authorizing Molina to release medical information for the facilitation of medical care.

Retrieval

- The medical record is available to the Provider at each encounter.
- The medical record is available to Molina for purposes of Quality improvement.
- The medical record is available to the applicable State and/or Federal agency and the external quality review organization upon request.
- The medical record is available to the member upon their request.
- A storage system for inactive Member medical records which allows retrieval within 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 treat mentor for a minor, one year past their 20th birthday but, never less than ten (10) years.
- An established and functional data recovery procedure in the event of data loss.

Confidentiality

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

- Ensure that medical information is released only in accordance with applicable Federal or State Law in pursuant to court orders or subpoenas.
- Maintain records and information in an accurate and timely manner.
- Ensure timely access by Members to the records and information that pertain to them.
- Abide by all Federal and State Laws regarding confidentiality and disclosure of medical records or other health and enrollment information.
- Protect medical records from unauthorized access.
- Restrict access to computerized confidential information.
- Take precautions to prevent inadvertent or unnecessary disclosure of protected health information.
- Educate and train all staff on handling and maintaining protected health care information.

Ensure that confidential information, such as patient race, ethnicity, preferred language, sexual orientation, gender identity, and social determinants of health is protected.

Additional information on medical records is available from your local Molina Quality department **toll free at (855) 237-6178.** For additional information regarding HIPAA please see the Compliance section of this Provider Manual.

Advance directives (Patient Self-Determination Act)

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

Advance directives are a written choice for health care. There are two (2) types of advance directives:

- Durable power of attorney for health care: allows an agent to be appointed to carry out health care decisions.
- Living will: allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration.

When there is no advance directive:

The Member's family and Provider will work together to decide on the best care for the Member based on information they may know about the Member's end-of-life plans.

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

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

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

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

In no event may any Provider refuse to treat a Member or otherwise discriminate against a Member because the Member has completed an advance directive. CMS regulations give 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 directive and/or if a Provider fails to comply with advance directive instructions.

Molina will notify the Provider of an individual Member's advance directives identified through Care Management, Care Coordination or Case Management. Providers are instructed to document the presence of an Advance Directive in a prominent location of the medical record. Advance Directive forms are State specific to meet State regulations.

Molina expects that there will be documented evidence of the discussion between the Provider and the Member during routine medical record reviews.

Access to care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care provided by contracted PCPs and participating specialists. Providers surveyed include PCPs (family/general practice, internal medicine, and pediatric), high-volume specialists and behavioral health Providers. 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 PCP or their designee must be available 24 hours a day, 7 days a week to Members.

Appointment access

All Providers who oversee the Member's health care are responsible for providing the following appointments to Molina Members in the timeframes noted. Walk-in patients should be seen as soon as possible. If they cannot be seen immediately, an appointment should be scheduled for them as soon as possible. Wait times for both walk-in and scheduled appointments must not exceed 45 minutes.

Emergency Provider Care	
Types of Care for Appointment	**Appointment Wait Time (Appointment Standards)**
Emergency Care	Immediately upon presentation at treatment site. Access by telephone for emergent medical conditions.
After-Hours Emergency Instructions	"If this is an emergency, please hang up and dial 911"
Primary Care Practitioner (PCP)	
Types of Care for Appointment	**Appointment Wait Time (Appointment Standards)**
Routine Primary Care	Within 15 business days
Urgent Care	Within 48 hours
Walk-in Patients	Should be seen if possible. Urgent needs must be seen within forty-eight hours of walk-in. Non-urgent needs must be seen within routine care guidelines above.
Office Wait Times	Within 45 minutes for a scheduled appointment of a routine nature
After-Hours Care	Available by phone 24 hours/seven days a week
Specialist Provider Care	
Types of Care for Appointment	**Appointment Wait Time (Appointment Standards)**
Emergent Visits	Immediately upon referral
Urgent Medical Condition Care	Within 48 hours of referral or notification of the Primary Care Physician
Routine Care (non-symptomatic)	Within 4 weeks and a maximum of 12 weeks for unique specialists. Wait time: within 45 minutes
Office wait times	Within 45 minutes for a scheduled appointment of a routine nature

Licensed Mental Health Professionals (Behavioral Health)	
Types of Care for Appointment	**Appointment Wait Time (Appointment Standards)**
Life Threatening Emergency	Immediately
Non-life Threatening Emergency	Immediately
Urgent Care	Within 48 hours
Initial Routine Care Visit	Within 10 business days
Follow-up Routine Care Visit	Within 15 business days of initial visit
Office wait times	Within 45 minutes for a scheduled appointment of a routine nature
Obstetricians and Gynecologists (OB-GYN)	
Types of Care for Appointment	**Appointment Wait Time (Appointment Standards)**
Emergent visits	Immediately upon presentation at a service delivery site
Routine visits	Within 15 business days
Urgent, non-emergent visits	Within 48 hours
Office wait times	Within 45 minutes for a scheduled appointment of a routine nature
Autism Therapy Services	
Types of Care for Appointment	**Appointment Wait Time (Appointment Standards)**
Emergent visits	Immediately upon presentation at a service delivery site
Routine visits	Within 15 business days
Urgent, non-emergent visits	Within 48 hours
Office wait times	Within 45 minutes for a scheduled appointment of a routine nature

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

Office wait time

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

After hours

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a 24 hour telephone service, 7 days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an Emergency to hang up and call 911 or go immediately to the nearest emergency room. Voicemail alone after-hours is not acceptable.

Women's health access

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

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

Monitoring access for compliance with standards

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

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

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

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

Quality of provider office sites

Molina Providers are to maintain office-site and medical record-keeping practice standards. Molina continually monitors Member appeals/grievances for all office sites to determine the

need for an office site visit and will conduct office site visits as needed. Molina assesses the quality, safety and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This includes an assessment of:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space

Physical accessibility

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

Physical appearance

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

Adequacy of waiting and examining room space

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

Administration & confidentiality of facilities

Facilities contracted with Molina must demonstrate 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 the 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 (2) 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 (1) 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, contracts, evidence of a hazardous waste management system in place.
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods.
- Confidential information is discussed away from patients.

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

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

EPSDT services to members from birth to age twenty-one (21) years

Molina maintains monitoring mechanisms to ensure all required EPSDT services to Members from birth to age twenty-one (21) years of age are timely according to required guidelines. All Members from birth to age twenty-one (21) years of age should receive screening examinations including appropriate childhood immunizations at intervals as specified by the EPSDT Program as set forth in §§1902(a)(43) and 1905(a)(4)(B) of the Social Security Act and 89 Ill. Adm. Code 140.485. Children under three years of age, who are screened at-risk for, or with developmental delay, must be referred to SCDHHS's Early Intervention Program for further assessment. Molina's QI or Provider Relations departments are also available to perform Provider training to ensure that best practice guidelines are followed in relation to Well-Child services and care for acute and chronic health care needs.

EPSDT services to members under 21 years of age

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

Well-child / adolescent visits

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

- Comprehensive health history.
- Nutritional assessment.
- Height and weight and growth charting.
- Comprehensive unclothed physical examination.
- Appropriate immunizations according to the Advisory Committee on Immunization Practices.
- Laboratory procedures, including lead blood level assessment appropriate for age and risk factors.
- Periodic developmental and behavioral screening using a recognized, standardized developmental screening tool, as approved by SCDHHS.
- Vision and hearing tests.
- Dental assessment and services.
- Health education, including anticipatory guidance such as child development, healthy lifestyles, accident and disease prevention.
- Periodic objective screening for social, emotional, development using a recognized, standardized tool, as approved by SCDHHS.
- Perinatal depression for mothers of infants in the most appropriate clinical setting, e.g., at the pediatric, behavioral health or OB/GYN visit.

Diagnostic services, treatment, or services Medically Necessary to correct or ameliorate defects, physical or mental illnesses, and conditions discovered during a screening or testing must be provided or arranged for either directly or through referrals. Any condition discovered during the screening examination or screening test requiring further diagnostic study or treatment must be provided if within the Member's covered benefit services. Members should be referred to an appropriate source of care for any required services that are not Covered Services. If, as a result of EPSDT services, it is determined that the Member is in need of services that are not covered services but are services otherwise provided for under the SCDHHS Program, Molina will ensure that the Member is referred to an appropriate source of care. Molina shall have no obligation to pay for services that are not covered services.

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 the improvement of care and service. Molina focuses on reducing health care disparities through the QI program. The goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Health management and care management

The Molina health management and care management programs provide for the identification, assessment, stratification, and implementation of appropriate interventions for Members with chronic diseases.

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

Clinical practice guidelines

Molina adopts and disseminates clinical practice guidelines (CPG) to Providers. All guidelines are based on scientific evidence, review of medical literature and/or appropriately established authority.

Molina's CPG's include the following:

- Acute Stress and Post Traumatic Stress Disorder (PTSD)
- Anxiety/Panic Disorder
- Asthma
- Attention-Deficit/Hyperactivity Disorder (ADHD)
- Autism
- Bipolar Disorder
- Children with Special Health Care Needs
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure in Adults
- Homelessness-Special Health Care Needs
- Hypertension
- Obesity
- Opioid Management
- Perinatal Care
- Pregnancy Management
- Sickle Cell Disease
- Schizophrenia
- Substance Abuse Treatment
- Suicide Risk
- Trauma-Informed Primary Care

All CPGs are reviewed at least quarterly and more frequently as needed to determine if the guideline has been updated when new scientific evidence is released, or national guidelines are published using appropriate practitioner input. On an annual basis

or when changes are made during the year, CPGs are distributed to Providers at MolinaHealthcare.com/providers/sc/medicaid/resource/clinical.aspx and the Provider Manual. Notification of the availability of the CPGs is published in the Molina Provider Newsletter.

Preventive health guidelines

Molina provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF), Bright Futures/American Academy of Pediatrics and the Centers for Disease Control and Prevention (CDC), in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include, but are not limited to:

- Adult Preventive Services Recommendations (U.S. Preventive Services Task Force). Links to current recommendations are included on Molina's website.
- Recommendations for Preventive Pediatric Health Care (Bright Futures/American Academy of Pediatrics). Links to current recommendations are included on Molina's website.
- Recommended Adult Immunization Schedule for ages 19 Years or Older, United States. These recommendations are revised every year by the Centers for Disease Control and Prevention. Links to current recommendations are included on Molina's website.
- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States. These recommendations are revised every year by the Centers for Disease Control and Prevention. Links to current recommendations are included on Molina's website.

All preventive health guidelines are reviewed at least quarterly and more frequently as needed to determine if the guideline has been updated when new scientific evidence is released, or national guidelines are published using appropriate practitioner input. On an annual basis or when changes are made during the year, Preventive Health Guidelines are distributed to Providers at MolinaHealthcare.com/providers/sc/medicaid/resource/prevent/prevent.aspx and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Cultural competency plan

Culturally and linguistically appropriate 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 Culturally and Linguistically Appropriate Services section of this Provider Manual.

Measurement of clinical and service quality

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

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

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

Contracted Providers and facilities must allow Molina to use its performance data collected in accordance with the Provider 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) reduced Member cost sharing

Molina's most recent results can be obtained from your local Molina Quality department or by visiting our website at MolinaHealthcare.com.

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. The results are used to evaluate the effectiveness of multiple quality improvement activities and clinical programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the effectiveness of these programs.

Selected HEDIS® results are provided to federal and state regulatory agencies and accreditation organizations. The data are also used to compare against established health plan performance benchmarks.

Consumer Assessment of Health Care Providers and Systems (CAHPS®)

CAHPS® is the tool used by Molina to summarize Member satisfaction with Providers, health care and service they receive. CAHPS® examines specific measures, including: getting needed care, getting care quickly, how well doctors communicate, coordination of care, customer service, rating of Health Care and getting needed prescription drugs (for Medicare). The CAHPS® survey is administered annually in the spring to randomly selected Members by a NCQA certified vendor.

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

Behavioral health satisfaction assessment

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

Provider satisfaction survey

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

Effectiveness of quality improvement initiatives

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

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

Provider profiling program

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

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

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

What can providers do?

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

Molina has additional resources to assist Providers and their patients. For access to tools that can assist, please visit the Availity Essentials portal. There are a variety of resources, including HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and CAHPS® survey Star Ratings measures, contact your local Molina Quality department.

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

Section 12 Risk adjustment accuracy and completeness

What is risk adjustment?

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

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

Interoperability

The Provider agrees to deliver relevant clinical documents (Clinical Document Architecture (CDA) or Continuity of Care Document (CCD) format) at encounter close for Molina Members by using one of the automated methods available and supported by Provider's electronic medical records (EMR), including, but not limited to, Epic Payer Platform, Direct Protocol, Secure File Transfer Protocol (sFTP), query or Web service interfaces such as Simple Object Access Protocol (External Data Representation) or Representational State Transfer (Fast Healthcare Interoperability Resource). The CDA or CCD document should include signed clinical note or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) Consolidated Clinical Data Architecture (CCDA) standard.

The Provider will also enable HL7 v2 Admission/Discharge/Transfer (ADT) feed for all patient events for Molina Members to the interoperability vendor designated by Molina.

The Provider will participate in Molina's program to communicate Clinical Information using the Direct Protocol. Direct Protocol is the Health Insurance Portability and Accountability Act (HIPAA) compliant mechanism for exchanging healthcare information that is approved by the Office of the National Coordinator for Health Information Technology (ONC).

- If the Provider does not have a Direct Address, Provider will work with its EMR vendor to set up a Direct Messaging Account, which also supports the Centers for Medicare & Medicare Services (CMS) Requirement of having Provider's Digital Contact Information added in the National Plan and Provider Enumeration System (NPPES).
- If the Provider's EMR does not support the Direct Protocol, Provider will work with Molina's established interoperability partner to get an account established.

Your role as a Provider

As a Provider, complete and accurate documentation in a medical record is critical to a Member's quality of care. We encourage Providers to record all diagnoses to the highest specificity. This will ensure Molina receives adequate resources to provide quality programs to you and our Members.

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

- Address clinical data elements (e.g., diabetic patient needs an eye exam or multiple comorbid conditions) provided by Molina and reviewed with the Member.
- Be compliant with the CMS National Correct Coding Initiative (NCCI).
- Use the correct ICD-10 code by documenting the condition to the highest level of specificity.
- Only use diagnosis codes confirmed during a Provider visit with a Member. The visit may be face-to-face, or telehealth, depending on state or CMS requirements.
- Contain a treatment plan and progress notes.
- Contain the Member's name and date of service.
- Have the Provider's signature and credentials.

Contact information

For questions about Molina's Risk Adjustment programs, please contact your Molina Provider Relations representative.

Section 13 Claims and compensation

Payer ID	46299
Availity Essentials portal	Availity.com/providers
Clean Claim Timely Filing	365 calendar days after the discharge for inpatient services or the Date of Service for outpatient services

Hospital-Acquired Conditions (HAC) and Present on Admission (POA) 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 evidence-based guidelines. CMS titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting."

The following is a list of CMS hospital acquired conditions. CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission:

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 (CABG)

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 Cardiac Implantable Electronic Device (CIED)
13. Iatrogenic Pneumothorax with Venous Catheterization
14. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
    a. Total Knee Replacement
    b. Hip Replacement

What this means to Providers:

- Acute Inpatient Prospective Payment System (IPPS) hospital Claims will be returned with no payment if the POA indicator is coded incorrectly or missing.
- No additional payment will be made on IPPS hospital Claims for conditions that are acquired during the patient's hospitalization.

For additional information on the Medicare HAC/POA program, including billing requirements, please refer to the CMS website at: cms.hhs.gov/HospitalAcqCond/.

Provider Preventable Conditions (PPCs)

In accordance with applicable federal and state requirements, providers must identify and report Provider Preventable Conditions (PPCs) associated with inpatient hospital services. PPCs include conditions that are reasonably preventable, within the control of the provider, and result in serious adverse outcomes, as defined by the South Carolina Department of Health and Human Services (SCDHHS) Hospital Services Provider Manual.

Providers are required to report PPCs when submitting claims for payment or member treatment for which payment would otherwise be made. All required documentation related to PPCs must be submitted to Molina and made available to the Department upon request.

No reduction in payment will be imposed for PPCs that existed prior to the initiation of treatment for the provider. Providers are responsible for maintaining processes to identify, report, and prevent PPCs in accordance with federal regulations, including 42 CFR §§ 438.3(g), 438.6(h)(2), and 447.26, and SCDHHS requirements.

Claim submission

Participating Providers are required to submit Claims to Molina with appropriate documentation. Providers must follow the appropriate State and Centers for Medicare & Medicaid Services (CMS) Provider billing guidelines as well as any criteria explicitly required in the Molina Provider billing manual and any criteria explicitly required in the Claim form instructions. Providers must utilize electronic billing though a clearinghouse or the Availity Essentials portal whenever possible and use current HIPAA compliant American National Standards Institute (ANSI) X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID number 46299.

Providers must bill Molina for services with the most current CMS-approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility Claims, the date of discharge. The following information must be included on every Claim:

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

Required elements

Electronic submitters should use the Implementation Guide and Molina Companion Guide for format and code set information when submitting or receiving files directly with Molina. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the Molina website at MolinaHealthcare.com/providers/sc/medicaid/home under EDI>Companion Guide for regularly updated information regarding Molina's Companion Guide requirements. Be sure to choose the appropriate state from the drop-down list on the top of the page. In addition to the Molina Companion Guide, it is also necessary to use the State Health Plan specific companion guides, which are also available on our Molina website for your convenience (remember to choose the appropriate state from the drop-down list).

Electronic Claim submissions will adhere to specifications for submitting medical Claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance Strategic National Implementation Process (SNIP) levels 1 to 5.

The following information must be included on every Claim, whether electronic or paper:

- 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) or Atypical Provider Identifier (API)
- 10-digit National Provider Identifier (NPI) of the Billing Provider or Group
- Rendering Provider information when different than billing
- Billing/Pay-to Provider name and billing address
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans
- National Drug Code (NDC), unit of measure and quantity for medical injectables
- E-signature
- Service facility location information
- Inpatient facility Claims require applicable condition, occurrence and value codes and applicable dates

Provider and Member data will be verified for accuracy and active status. Be sure to validate this data in advance of Claim submission. This validation will apply to all Provider data submitted and also applies to atypical and out-of-state Providers.

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. Molina supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. Molina may validate the NPI submitted in a Claim transaction is a valid NPI and is recognized as part of the NPPES data.

Electronic Claim submission

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

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

Molina offers the following Electronic Claim submission options:

- Submit Claims directly to Molina via the Availity Essentials portal
- Submit Claims to Molina via your regular EDI clearinghouse using Payer ID 46299.

Availity Essentials portal

The Availity Essentials portal is a no cost online platform that offers a number of Claim processing features:

- Submit Professional (CMS1500) and Institutional (CMS-1450 [UB04]) Claims with attached files.
- Correct/ void Claims.
- Add attachments to previously submitted Claims.
- Check Claim status.
- Create and manage Claim templates.
- Create and submit a Claim appeal with attached files.
- Manage overpayment invoices (Inquire, Dispute and Resolve)

Clearinghouse:

Molina uses SSI Claimsnet as its gateway clearinghouse. SSI Claimsnet has relationships with hundreds of other clearing houses. Typically, Providers can continue to submit Claims to their usual clearinghouse.

If you do not have a clearinghouse, Molina offers additional electronic claims submissions options as shown by logging on to the Availity Essentials portal.

Molina accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for institutional. In order to ensure that all data being submitted to our gateway is received properly your submitter must utilize the latest version of the 837 standard. It is important to track your electronic transmissions using your acknowledgment reports. The reports assure Claims are received for processing in a timely manner.

When claims are filed via a clearinghouse

- You should receive a 999 acknowledgment from your clearinghouse.
- You should also receive 227CA response file with initial status of the Claim from your clearinghouse.
- You should contact your local clearinghouse representative if you experience any problems with your transmission.
- You should refer to the Molina Companion Guide for information on the response format and messages.

EDI claim submission issues

Providers who are experiencing EDI submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider should contact their Provider relations representative for additional support.

Paper Claim submission

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

When submitting paper Claims:

- Paper Claim submissions are not considered to be "accepted" until received at the appropriate Claims PO Box; Claims received outside of the designated PO Box will be returned for appropriate submission.
- Paper Claims are **required** to be submitted on original red and white CMS-1500 and CMS-1450 (UB-04) Claim forms.
- Paper Claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms, and any altering to include Claims with handwriting.

- Claims must be typed with either ten (10) or twelve (12) point Times New Roman font, using black ink.
- Link to paper Claims submission guidance from CMS: cms.gov/Medicare/Billing/ElectronicBillingEDITrans/1500.

Corrected Claim process

Providers may correct any necessary field of the CMS-1500 and CMS-1450 (UB-04) forms.

Molina strongly encourages participating Providers to submit Corrected Claims electronically via EDI or, Availity Essentials portal.

All Corrected Claims:

- Must be free of handwritten or stamped verbiage (paper Claims).
- Must be submitted on a standard red and white CMS-1450 (UB-04) or CMS-1500 Claim form (paper Claims).
- Original Claim number must be inserted in field 64 of the CMS-1450 (UB-04) or field 22 of the CMS-1500 of the paper Claim, or the applicable 837 transaction loop for submitting corrected claims electronically.
- The appropriate frequency code/resubmission code must also be billed in field 4 of the CMS-1450 (UB-04) and 22 of the CMS-1500.

Note: The frequency/resubmission codes can be found in the National Uniform Claim Committee (NUCC) manual for CMS-1500 Claim forms or the Uniform Billing (UB) Editor for CMS-1450 (UB-04) Claim forms.

Corrected Claims must be sent within 365 calendar days of date of service of the Claim.

Corrected claims submission options:

- Submit Corrected Claims directly to Molina via the Availity Essentials portal.
- Submit corrected Claims to Molina via your regular EDI clearinghouse.

Coordination of benefits (COB) and third-party liability (TPL)

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured, or self-funded, or commercial carrier, automobile insurance, and worker's compensation) or program that is or may be liable to pay all or part of the health care expenses of the Member.

Medicaid is always the payer of last resort and Providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Molina Members. If third party liability can be established, Providers must bill the primary payer and submit a primary explanation of benefits (EOB) to Molina for secondary Claim processing. In the event

that coordination of benefits occurs, Provider shall be reimbursed based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including EOB and other required documents. Molina will pay claims for School Based Mental Health Services, preventive pediatric services, dental EPSDT services and certain Department of Health and Environmental Control (DHEC) services under Title V, and then seek reimbursement from third parties. If services and payment have been rendered prior to establishing third party liability, an overpayment notification letter will be sent to the Provider requesting a refund including third party policy information required for billing.

Subrogation - Molina retains the right to recover benefits paid for a Member's health care services when a third party is responsible for the Member's injury or illness to the extent permitted under State and Federal law and the Member's benefit plan. If third party liability is suspected or known, please refer pertinent case information to Molina's vendor at: submitreferrals@katchiq.com

Timely claim filing

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

Molina coding policies and payment policies

Frequently requested information on Molina's coding policies and payment policies is available on the MolinaHealthcare.com website under the Policies tab. Questions can be directed to your Provider Relations representative.

Reimbursement guidance and payment guidelines

Providers are responsible for submission of accurate Claims. Molina requires coding of both diagnoses and procedures for all Claims as follows:

- For diagnoses, the required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM

- For procedures:
    - Professional and outpatient Claims, require the Healthcare Common Procedure Coding System, Current Procedural Terminology Level one (CPT codes), Level 2 and 3 HCPCS codes
    - Inpatient hospital Claims require international Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) coding schemes

Furthermore, Molina requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

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

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

Telehealth Claims and billing

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

All telehealth Claims for Molina Members must be submitted to Molina with correct codes for the plan type in accordance with applicable billing guidelines. For guidance, please refer to the resources located at scdhhs.gov/provider-manual-list or Report (Vertical) (scdhhs.gov/)

National Correct Coding Initiative (NCCI)

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

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

General coding requirements

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

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

CPT and HCPCS codes

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

Modifiers

Modifiers consist of two alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers may be appended only if

the clinical circumstances justify the use of the modifier(s). For example, modifiers may be used to indicate whether a:

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

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

ICD-10-CM/PCS codes

Molina utilizes International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and International Classification of Diseases 10th Revision, Procedure Coding System (ICD-10-PCS) billing rules and will deny Claims that do not meet Molina's ICD-10 Claim submission guidelines. To ensure proper and timely reimbursement, codes must be effective on the date of service 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

POS codes 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 code should be indicative of where that specific procedure/service was rendered. If billing multiple lines, each line should indicate the POS code for the procedure/service on that line.

Type of bill

Type of bill is a four-digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC) Official CMS-1450 (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 CMS-1450 (UB-04) Data Specifications Manual.

Diagnosis Related Group (APR DRG)

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

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

National Drug Code (NDC)

The NDC number must be reported on all professional and outpatient Claims when submitted on the CMS-1500 Claim form, CMS-1450 (UB-04), or its electronic equivalent.

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

Coding sources

Definitions

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

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

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

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

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

Claim auditing

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

The Provider acknowledges Molina's right to conduct pre and post-payment billing audits. The Provider shall cooperate with Molina's Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, the Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Additionally, Providers are required, by contract and in accordance with the Provider Manual, to submit all supporting medical records/documentation as requested. 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 reserves the right, and where unprohibited by regulation, to 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 extrapolated across all Claims to determine the amount of overpayment.

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

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

EDI (clearinghouse) submission

Corrected Claim information submitted via EDI submission are required to follow electronic Claim standardized ASC X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 7. The 837 Claim format allows you to submit changes to Claims that were not included on the original adjudication.

The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called "Claim

frequency codes." Using the appropriate code, you can indicate that the Claim is an adjustment of a previously submitted finalized Claim. Use the below frequency codes for Claims that were previously adjudicated.

Claim Frequency Code	Description Action
7	Use to replace an entire Claim. Molina will adjust the original Claim. The corrections submitted represent a complete replacement of the previously processed Claim.
8	Use to eliminate a previously submitted Claim. Molina will void the original Claim from records based on request.

When submitting Claims noted with Claim frequency code 7 or 8, the original Claim number, must be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The original Claim number can be obtained from the 835 Electronic Remittance Advice (ERA). Without the original Claim number, adjustment requests will generate a compliance error and the Claim will reject.

Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original Claim number will not be adjusted.

Timely claim processing

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

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

Electronic claim payment

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

Overpayments and incorrect payments refund requests

In accordance with 42 CFR 438.608, Molina requires network Providers to report to Molina when they have received an overpayment and to return the overpayment to Molina within 60 calendar days after the date on which the overpayment was identified and notify Molina in writing of the reason for the overpayment.

If, as a result of retroactive review of Claim payment, Molina determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a Claim for such Overpayment. Providers will receive an overpayment request letter if the overpayment is identified in accordance with State and CMS guidelines. Providers will be given the option to either:

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

A copy of the overpayment request letter and details are available in the Availity Essentials portal. In the Overpayment Application section, Providers can make an inquiry, contest an overpayment with supporting documentation, resolve an overpayment, or check status. This is Molina's preferred method of communication.

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

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

A Provider shall pay a Claim for an Overpayment made by Molina which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider. If a Provider does not repay or dispute the overpaid amount within the timeframe allowed Molina may offset the overpayment amount(s) against future payments made to the Provider.

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

Claim disputes/reconsiderations/appeals

Information on Claim Disputes/Reconsiderations/Appeals is located in the A&G section of this Provider Manual.

Balance billing

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

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

Fraud, waste, and abuse

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

Encounter data

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

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

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

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

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

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

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

Section 14 Compliance

Fraud, waste, and abuse

Introduction

Molina is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Molina's Compliance department maintains a comprehensive plan, which is designed to address how will uphold and follow State and Federal statutes and regulations pertaining to fraud, waste, and abuse. The plan also addresses fraud, waste, and abuse prevention, detection, and correction along with the education of appropriate employees, vendors, Providers and associates doing business with Molina.

Molina's Special Investigation Unit (SIU) supports Compliance in its efforts to prevent, detect, and correct 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

Our mission is to pay claims correctly the first time, and that mission begins with the understanding that we need to proactively detect fraud, waste, and abuse, correct it, and prevent it from reoccurring. Since not all fraud, waste, or abuse can be prevented, Molina employs processes that retrospectively address fraud, waste, or abuse that may have already occurred. Molina strives to detect, prevent, investigate, and report suspected health care fraud, waste, and abuse in order to reduce health care costs and to promote quality health care.

Regulatory requirements

Federal False Claims Act

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

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

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

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

Deficit Reduction Act

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

As a contractor doing business with Molina, Providers and their staff have the same obligation to report any actual or suspected violation or fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

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

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

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

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

Affected entities who fail to comply with the Law will be at risk of forfeiting all payments until compliance is met. Molina will take steps to monitor Molina contracted Providers to ensure compliance with the law. Health care entities (e.g., providers, facilities, delegates and/or vendors) to which Molina has paid $5 million or more in Medicaid funds during the previous federal fiscal year (October 1-September 30) will be required to submit a signed "Attestation of Compliance with the Deficit Reduction Act of 2005, Section 6032" to Molina.

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

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

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

What is AKS?

AKS statutes and regulations prohibit paying or receiving anything of value to induce or reward patient referrals or the generation of business involving any item or service payable by Federal and State health care programs. The phrase "anything of value" can mean cash, discounts, gifts, excessive compensation, contracts not at fair market value, etc. Examples of prohibited AKS actions include a health care Provider who is compensated based on patient volume, or a Provider who offers remuneration to patients to influence them to use their services.

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

Marketing guidelines and requirements

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

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

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

Stark Statute – The Physicians Self-Referral Law (Stark Law) prohibits physicians from referring patients to receive "designated health services" payable by Medicare of Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. The Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. "Designated health services" are identified in the Physician Self-Referral Law (42 U.S.C. § 1395nn).

Sarbanes - Oxley Act of 2002 – 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 themself or some other person. It includes any act that constitutes fraud under applicable federal or state law. (42 CFR § 455.2)

Waste: means health care spending that can be eliminated without reducing the quality of care. Quality waste includes overuse, under use, and ineffective use. Inefficiency waste includes redundancy, delays, and unnecessary process complexity. An example would be the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g., coding) causes unnecessary costs to State and Federal health care programs.

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

Examples of fraud, waste and abuse by a Provider

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

- A Provider knowingly and willfully referring a Members to health care facilities in which or with which the Provider has a financial relationship. (Stark Law)
- Altering Claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a Medicaid Member for covered services. This includes asking the Member to pay the difference between the discounted fees, negotiated fees, and the Provider's usual and customary fees.
- Billing and providing for services to Members that are not medically necessary.
- Billing for services, procedures and/or supplies that have not been rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.
- Completing certificates of medical necessity for Members not personally and professionally known by the Provider.
- Concealing a Member's misuse of a Molina ID 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 service that costs more.
- Using the adjustment payment process to generate fraudulent payments.

Examples of fraud, waste, and abuse by a Member

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

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

Review of provider claims and claim system

Molina Claims Examiners are trained to recognize unusual billing practices, which are key in trying to identify fraud, waste, and abuse. If the Claims Examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the SIU through our Compliance Alertline/reporting repository.

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

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

Provider profiling

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

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

Prepayment of fraud, waste, and abuse detection activities

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

Molina has a prepayment Claim 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, federal CMS guidelines, American Medical Association (AMA) and published specialty-specific coding rules. Code edit rules are based on information received from the National Physician Fee Schedule Relative File (NPFS), the Medically Unlikely Edit (MUE) table, National Correct Coding Initiative (NCCI) files, Local Coverage Determination/National Coverage Determination (LCD/NCD), and State-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

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

Post-payment recovery activities

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

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

The 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 the 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 are immediately due and owing. If Provider fails to provide all requested documentation for any Claim, the entire amount of the paid Claim is immediately due and owing. Molina may offset such amounts against any amounts owed by Molina to Provider. Provider must comply with all requests for documentation and records timely (as reasonably requested by Molina) and without charge to Molina. Claims for which Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to charge-back.

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 164.501). Provider further acknowledges that in order to receive payment from Molina, Provider is required to allow Molina to conduct audits of its pertinent records to verify the services performed and the payment claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy Laws.

Claim auditing

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

The Provider acknowledges Molina's right to conduct pre and post-payment billing audits. The Provider shall cooperate with Molina's Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, Provider's charging policies, and other related data as deemed relevant to support the transactions billed.

Additionally, Providers are required, by contract and in accordance with the Provider Manual, to submit all supporting medical records/documentation as requested. 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 reserves the right and where unprohibited by regulation, to 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 extrapolated across all Claims to determine the amount of overpayment.

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

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

Medical records

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

- Patient information sheets (completed by patient, parent, or guardian)
- Financial records including superbills, 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
PO Box 22625
Long Beach, CA 90802

Provider education

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

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

Cooperating with special investigation unit activities

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

Reporting fraud, waste and abuse

Suspected cases of fraud, waste, or abuse, must be reported to Molina by contacting the Molina Alertline. The Molina Alertline is an external telephone and web-based reporting system hosted by Global Compliance, a leading Provider of compliance and ethics hot line services. The Molina Alertline telephone and web-based reporting is available 24 hours a day, 7 days a week, 365 days a year. When a report is made, callers can choose to remain confidential or anonymous. When calling the Molina Alertline, a trained professional at Global Compliance will note the caller's concerns and provide them to the Molina Compliance department for follow-up. When electing to use the web-based reporting process, a series of questions will be asked concluding with the submission of the report. Reports to the Molina Alertline can be made from anywhere within the United States with telephone or internet access.

The Molina Alertline can be reached at (866) 606-3889 or you may use the service's website to make a report at any time at MolinaHealthCare.Alertline.com.

Fraud, waste or abuse cases may also be reported to Molina's Compliance department 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:

South Carolina Department of Health and Human Services
Medicaid Fraud and Abuse Hotline
Phone: (888) 364-3224
By Email: fraudres@scdhhs.gov

South Carolina Attorney General
Vulnerable Adults and Medicaid Provider Fraud Unit
By Phone: (803) 734-3660 or (888) 662-4328
By Email: VAMPF@scag.gov
Or mail complaint to:
South Carolina Attorney General's Office
Vulnerable Adults and Medicaid Provider Fraud
Post Office Box 11549
Columbia, SC 29211-1549

HIPAA (Health Insurance Portability & Accountability Act) Requirements and Information

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 Providers will respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI. Molina provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Molina uses and discloses 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 the privacy of health information including, without limitation, the following:

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

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

Artificial intelligence

Provider shall comply with all applicable state and federal laws and regulations related to artificial intelligence and the use of artificial intelligence tools (AI). Artificial Intelligence or AI means a machine-based system that can, with respect to a given set of human-defined objectives, input or prompt, as applicable, make predictions, recommendations, data sets, work product (whether or not eligible for copyright protection), or decisions influencing physical or virtual environments. The Provider is prohibited from using AI for any functions that result in a denial, delay, reduction, or modification of covered services to Molina Members including, but not limited to utilization management, prior authorizations, complaints, appeals and grievances, and quality of care services, without review of the denial, delay, reduction or modification by a qualified clinician. In addition, the Provider shall not use AI-generated voice technology, including but not limited to AI voice bots, voice cloning, or synthetic speech systems to initiate or conduct outbound communications to Molina. The prohibition includes, but is not limited to, communications for billing, eligibility verification, prior authorization, or any other administrative function.

Notwithstanding the foregoing, the Provider shall give advance written notice to your Molina Contract Manager (for any AI used by the Provider that may impact the provision of Covered Services to Molina Members) that describes (i) Providers' use of the AI tool(s) and (ii) how the Provider oversees, monitors and evaluates the performance and legal compliance of such AI tool(s). If the use of AI is approved by Molina, the Provider further agrees to (i) allow Molina to audit Providers' AI use, as requested by Molina from time to time, and (ii) to cooperate with Molina with regard to any regulatory inquiries and investigations related to Providers' AI use related to the provision of covered services to Molina Members.

If you have additional questions, please contact your Molina Contract Manager.

Uses and disclosures of PHI

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

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as pre-authorization of services, concurrent review, and retrospective review of "services[2]."

[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

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:
    - Quality improvement
    - Disease management
    - Care management and care coordination
    - Training programs
    - Accreditation, licensing, and credentialing

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

Confidentiality of substance use disorder patient records

Federal Confidentiality of Substance Use Disorder Patient Records under 42 USC § 290dd-2 and 42 CFR Part 2 (collectively, "42 CFR Part 2") apply to any entity or individual providing federally assisted alcohol or drug abuse prevention treatment.

"SUD Records" means PHI that includes substance use disorder treatment information that is protected under 42 CFR Part 2. Providers that are Part 2 Programs must comply with the requirements of 42 CFR Part 2, as amended from time to time.

SUD Records are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, 42 CFR Part 2 is more restrictive than HIPAA and does not allow disclosure without the patient's written consent except as set forth in 42 CFR Part 2. Any disclosure of SUD Records to Molina with the written consent of the patient, by a Provider that is a Part 2 Program, must meet the notice requirements of 42 CFR Part 2, specifically Sections 2.31 and 2.32, and shall include a copy of the patient's consent or a clear explanation of the scope of the consent provided.

Providers that are Part 2 Programs pursuant to 42 CFR Part 2 must promptly inform Molina that they are a Part 2 Program.

Inadvertent disclosures of PHI

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

Written authorizations

Uses and disclosures of PHI that are not permitted or required under applicable Law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable State Law.

Patient rights

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

1. **Notice of privacy practices**
   Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a Notice of Privacy Practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the Notice of Privacy Practices.
2. **Requests for restrictions on uses and disclosures of PHI**
   Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.
3. **Requests for confidential communications**
   Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.
4. **Requests for patient access to PHI**
   Patients have a right to access their own PHI within a Provider designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.
5. **Request to amend PHI**
   Patients have a right to request that the Provider amend information in their designated record set.
6. **Request accounting of PHI disclosures**
   Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six-year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations.

HIPAA security

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

Medical identity theft is an emerging threat in the health care industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity – such

as health insurance information – without the person's knowledge or consent to obtain health care services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Molina.

HIPAA transactions and code sets

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

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

Molina is committed to complying with all HIPAA Transaction and Code Sets standard requirements.

Code sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions.

National Provider Identifier (NPI)

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

Additional requirements for delegated providers

Providers that are delegated for Claims and utilization management activities are the "business associates" of Molina. Under HIPAA, Molina must obtain contractual assurances from all business associates that they will safeguard Member PHI. Delegated Providers must agree to various contractual provisions required under HIPAA's privacy and security rules.

Additional Requirements for Delegated Providers and Atypical Providers

Providers that are delegated for Claims and Utilization Management activities ("Delegated Providers") are the "Business Associates" of Molina for the delegated functions performed on behalf of Molina. Providers that provide services to Molina members but who are not health care providers under HIPAA ("Atypical Providers") are the Business Associates of Molina. Under HIPAA, Molina must obtain contractual assurances from all Business Associates that they will safeguard Molina Member PHI. Delegated Providers and Atypical Providers must agree to various contractual provisions required under HIPAA's privacy and security rules, including entering into a Business Associate Agreement with Molina. Delegated Providers and Atypical Providers agree to comply with the following HIPAA Business Associate Agreement requirements.

HIPAA Required Business Associate Agreement

Applicability: This HIPAA Required Business Associate Agreement ("BAA") sets forth the requirements with which the Business Associate must comply when it receives or has access to Protected Health Information ("PHI") in the performance of Services under the Agreement(s) and with respect to that PHI.

1. DEFINITIONS

Unless otherwise provided for in this BAA, terms used in this BAA shall have the same meanings as set forth in the HIPAA Rules including, but not limited to the following: "Availability," "Confidentiality," "Covered Entity," "Data Aggregation," "Designated Record Set," "Health Care Operations," "Integrity," "Minimum Necessary," "Notice of Privacy Practices," "Required By Law," "Secretary," and "Subcontractor." Specific definitions are as follows:

"Breach" shall have the same meaning as the term "breach" at 45 CFR 164.402.

"Business Associate" shall have the same meaning as the term "business associate" at 45 CFR 160.103 and in reference to the party to this BAA, shall mean the Provider subject to this BAA.

"Compliance Date" shall mean, in each case, the date by which compliance is required under the referenced provision of the HIPAA, the HITECH Act or the HIPAA Rules, as applicable; provided that, in any case for which that date occurs prior to the effective date of this BAA, the Compliance Date shall mean the effective date of this BAA.

"Covered Entity" or "Molina" shall mean Molina Healthcare of South Carolina.

"Electronic Protected Health Information" or "Electronic PHI" shall have the same meaning as the term "electronic protected health information" at 45 CFR 160.103.

"HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

"Party or Parties" shall mean Covered Entity and Business Associate who parties to this BAA.

"Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" at 45 CFR 160.103.

"Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164.

"Security Incident" shall have the same meaning as the term "security incident" at 45 CFR 164.304.

"Security Rule" means the Security Standards for the Protection of Electronic Protected Health Information, set forth at 45 CFR Parts 160 and 164.

"Services" shall mean, to the extent and only to the extent they involve the creation, use, maintenance, transmission, or disclosure of PHI, the services provided by the Business Associate to Molina under the Agreement(s), including those set forth in this BAA, as amended by written consent of the parties from time to time.

"SUD Records" means PHI that includes substance use disorder treatment information that is protected under 42 USC §290dd-2 and 42 CFR Part 2 (collectively, "42 CFR Part 2").

"Unsecured PHI" shall have the same meaning as the term "unsecured Protected Health Information" at 45 CFR 164.402.

2. GENERAL PROVISIONS

2.1. Effect. This BAA supersedes any prior business associate agreement between the Parties and those portions of any Agreement between the Parties that involve the disclosure of PHI by Molina to Business Associate. To the extent any conflict or inconsistency between this BAA and the terms and conditions of any Agreement exists, the terms of this BAA shall prevail.

2.2. Amendment. Molina may, without Business Associate's consent, amend this BAA to maintain consistency and/or compliance with any state or federal law, policy, directive, regulation, or government sponsored program requirement, upon forty-five (45) business days' notice to the Business Associate unless a shorter timeframe is necessary for compliance. Molina may otherwise materially amend this BAA only after forty-five (45) business days prior written notice to the Business Associate and only if mutually agreed to by the Parties as evidenced by the amendment being executed by each Party hereto. If the Parties fail to execute a mutually agreeable amendment within forty-five (45) days of the Business Associate's receipt of Molina's written notice to amend this BAA, Molina shall have the right to immediately terminate this BAA and any Agreement(s) between the Parties which may require the Business Associate's use or disclosure of PHI in performance of services described in such Agreement(s) on behalf of Molina.

3. SCOPE OF USE AND DISCLOSURE

3.1. The Business Associate may use or disclose PHI as required to provide Services and satisfy its obligations under the Agreement(s), if such use or disclosure of PHI would not violate the Privacy Rule.

3.2. The Business Associate may not use or further disclose PHI in a manner that would violate the Privacy Rule if done by Molina, except that the Business Associate may use or disclose PHI as necessary:

a. for the proper management and administration of the Business Associate as provided in Section 3.3; and

b. to provide Data Aggregation services relating to the Health Care Operations of Molina if required under the Agreement.

3.3. The Business Associate may use or disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Any disclosures of PHI under this section may be made only if:

a. the disclosures are required by law, or

b. the Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that the PHI will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached.

3.4. The Business Associate shall not request, use or release more than the Minimum Necessary amount of PHI required to accomplish the purpose of the use or disclosure and shall comply with 42 U.S.C. § 17935(b) as of its Compliance Date. The Business Associate hereby acknowledges that all PHI created or received from, or on behalf of, Molina, is as between the Parties, the sole property of Molina.

3.5. The Business Associate or its agents or Subcontractors shall not perform any work outside the United States of America that involves access to, use of, or disclosure of, PHI without the prior written consent of Molina in each instance. Further, the Business Associate or its agents or Subcontractors shall not transmit or store PHI outside of the United States of America without Molina's prior written consent.

3.6. The Business Associate agrees to be fully bound by the requirements of 42 CFR Part 2 upon receipt of any SUD Records disclosed under this Agreement. The Business Associate shall not use or disclose SUD Records except as necessary for the Business Associate to perform Services. The Business Associate shall not redisclose any SUD Records to a third party, except to a contract agent acting on the Business Associate's behalf to provide Services or back to Molina. The contract agent may only redisclose such information to the Business Associate or Molina. The Business Associate and any contract agent shall not disclose SUD Records for use in any civil, criminal, administrative or legislative proceeding against the individual who is the subject of the SUD Record and shall immediately notify Molina of any such request. The Business Associate must ensure that any such contract agent agrees in writing to these same restrictions and obligations set forth in this Section.

4. OBLIGATIONS OF THE BUSINESS ASSOCIATE

The Business Associate shall:

4.1. Not use or disclose PHI other than permitted or required by this BAA or as Required by Law.

4.2. Establish and use appropriate safeguards to prevent the unauthorized use or disclosure of PHI.

4.3. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of Molina. The Business Associate shall, as of the Compliance Date, comply with the applicable standards at Subpart C of 45 CFR Part 164.

4.4. Promptly report to Molina any unauthorized use or disclosure of PHI, Breach of Unsecured PHI, or Security Incident, within no more than five (5) days, after Business Associate becomes aware of the unauthorized use or disclosure of PHI, Breach of Unsecured PHI or Security Incident. The Business Associate shall take all reasonable steps to mitigate any harmful effects of such unauthorized use or disclosure, Breach of Unsecured PHI, or Security Incident. The Business Associate shall indemnify Molina against any losses, damages, expenses or other liabilities including reasonable attorney's fees incurred as a result of the Business Associate's or its agent's or Subcontractor's unauthorized use or disclosure of PHI, Breach of Unsecured PHI, or Security Incident, including, but not limited to, the costs of notifying individuals affected by a Breach of Unsecured PHI and the provision of two years of credit monitoring and identity protection services to the affected individuals. Indemnification is subject to an ability to demonstrate that no agency relationship exists between the parties.

4.5. The Business Associate shall, following discovery of a Breach of Unsecured PHI, notify Molina of such Breach as required at 45 CFR 164.410, without unreasonable delay, and in no event more than thirty (30) days after the discovery of the Breach. The notification by the Business Associate to Molina shall include: (1) the identification of each individual whose Unsecured PHI was accessed, acquired, used or disclosed during the Breach; and (2) any other available information that Molina is required to include in its notification to individuals affected by the Breach including, but not limited to, the following:

a. a brief description of what happened, including the date of the Breach and the date of the discovery of the Breach;

b. a description of the types of Unsecured PHI that were involved in the Breach; and

c. a brief description of what the Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches.

4.6. In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any Subcontractors or agents that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information.

4.7. Within ten (10) days of receiving a request, make available PHI in a Designated Record Set to Molina as necessary to satisfy Molina's obligations under 45 CFR 164.524.

4.8. Within fifteen (15) days of receiving a request, make any amendment(s) to PHI in a Designated Record Set as directed or agreed to by Molina pursuant to 45 CFR 164.526.

4.9. Maintain and make available to Molina, within twenty (20) days of receiving a request, the information required to provide an accounting of disclosures to the individual as necessary to satisfy Molina's obligations under 45 CFR 164.528.

4.10. Make its internal practices, books and records relating to the use or disclosure of PHI received from or on behalf of Molina available to Molina or the U. S. Secretary of Health and Human Services for purposes of determining compliance with the HIPAA Rules.

4.11. To the extent the Business Associate conducts Standard Transaction(s) (as defined in the HIPAA Rules) on behalf of Molina, Business Associate shall comply with the HIPAA Rules, "Administrative Requirements," 45 C.F.R. Part 162, by the applicable compliance date(s) and shall not: (a) change the definition, data condition or use of a data element or segment in a standard; (b) add any data elements or segments to the maximum defined data set; (c) use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s); or (d) change the meaning or intent of the standard's implementation specifications. The Business Associate shall comply with any applicable certification and compliance requirements (and provide the Secretary with adequate documentation of such compliance) under subsection (h) of Title 42 U.S.C. Section 1320d-2.

4.12. To the extent the Business Associate is to carry out one or more of Molina's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to Molina in the performance of such obligation(s).

5. MISCELLANEOUS

5.1. Indemnification. In addition to any indemnities set forth in the Agreement(s), each party will indemnify and defend the other party from and against any and all claims, losses, damages, expenses or other liabilities, including reasonable attorney's fees, incurred as a result of any breach by such party of any representation, warranty, covenant, agreement or other obligation expressly contained herein by such party, its employees, agents, Subcontractors or other representatives.

5.2. Interpretation. Any ambiguity in this BAA shall be interpreted to permit compliance with the HIPAA Rules.

5.3. No Third Party Beneficiaries. Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

5.4. Governing Law and Venue. This BAA shall be governed by South Carolina law notwithstanding any conflicts of law provisions to the contrary. The venue shall be the jurisdiction where the applicable services were received by Molina.

5.5. Compliance with Confidentiality Laws. The Business Associate acknowledges that it must comply with all applicable laws that may protect the confidentiality of PHI or other personally identifiable information received and will comply with all such laws.

5.6. Notices. Any notices to be given hereunder to Molina shall be made via certified U.S. Mail or express courier to Molina's address given below, and/or (other than for the delivery of fees) via email to the email listed below:

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

Attn: Privacy Official
Email: PrivacyOfficial@MolinaHealthcare.com

6. TERM AND TERMINATION OF BAA

6.1. Term. The Term of this BAA shall be effective as of the effective date set forth in the first paragraph of this BAA, and shall terminate on date that the last Agreement remaining in force between the parties is terminated or expires, or on the date Molina terminates for cause as authorized in paragraph 6.2 below, whichever is sooner.

6.2. Termination for Cause. Notwithstanding any other provision of this BAA or the Agreement(s), Molina may terminate this BAA and any or all Agreement(s) upon five (5) days written notice to Business Associate if Molina determines, in its sole discretion, that Business Associate has violated a material term of this BAA.

6.3. Obligations of Business Associate Upon Termination. Upon termination of this BAA for any reason, Business Associate shall return to Molina or, if agreed to by Molina, destroy all PHI received from Molina, or created, maintained, or received by Business Associate on behalf of Molina, that the Business Associate still maintains in any form. If PHI is destroyed, Business Associate agrees to provide Molina with certification of such destruction. Business Associate shall not retain any copies of PHI except as Required by Law. If return or destruction of all PHI, and all copies of PHI, received from Molina, or created, maintained, or received by Business Associate on behalf of Molina, is not feasible, Business Associate shall:

a. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to Electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section 6, for as long as Business Associate retains the PHI; and

a. Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set forth in Section 3 above which applied prior to termination.

6.4. Survival. The obligations of Business Associate under this Section shall survive the termination of this BAA and remain in force as long as Business Associate stores or maintains PHI in any form or format (including archival data). Termination of the BAA shall not affect any of the provisions of this BAA that, by wording or nature, are intended to remain effective and to continue in operation.

Reimbursement for copies of PHI

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

- Utilization management
- Care coordination and/or complex medical care management services
- Claims review

- Resolution of an appeal and/or grievance
- Anti-fraud program review
- Quality of care issues
- Regulatory audits
- Risk adjustment
- Treatment, payment, and/or operation purposes
- Collection of HEDIS® medical records

Information security and cybersecurity

NOTE: This section (Information Security and Cybersecurity) is only applicable to Providers who have been delegated by Molina to perform a health plan function(s), and in connection with such delegated functions.

Definitions:

(a.) "Molina Information" means any information: (i) provided by Molina to Provider; (ii) accessed by Provider or available to Provider on Molina's Information Systems; or (iii) any information with respect to Molina or any of its consumers developed by Provider or other third parties in Provider's possession, including without limitation any Molina Nonpublic Information.

(b.) "Cybersecurity Event" means any actual or reasonably suspected contamination, penetration, unauthorized access or acquisition, or other breach of confidentiality, data integrity or security compromise of a network or server resulting in the known or reasonably suspected accidental, unauthorized, or unlawful destruction, loss, alteration, use, disclosure of, or access to Molina Information. For clarity, a Breach or Security Incident as these terms are defined under HIPAA constitute a Cybersecurity Event for the purpose of this section. Unsuccessful security incidents, which are activities such as pings and other broadcast attacks on Provider's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, do not constitute a Cybersecurity Event under this definition so long as no such incident results in or is reasonably suspected to have resulted in unauthorized access, use, acquisition, or disclosure of Molina Information, or sustained interruption of service obligations to Molina.

(c.) "HIPAA" means the Health Insurance Portability and Accountability Act, as may be amended from time to time.

(d.) "HITECH" means the Health Information Technology for Economic and Clinical Health Act, as may be amended from time to time.

(e.) "Industry Standards" mean as applicable, codes, guidance (from regulatory and advisory bodies, whether mandatory or not), international and national standards, relating to security of network and information systems and security breach and incident reporting requirements, all as amended or updated from time to time, and including but not limited

to the current standards and benchmarks set forth and maintained by the following, in accordance with the latest revisions and/or amendments:

i. HIPAA and HITECH_

ii. HITRUST Common Security Framework

iii. Center for Internet Security

iv. National Institute for Standards and Technology ("NIST") Special Publications 800.53 Rev.5 and 800.171 Rev. 1, or as currently revised

v. Federal Information Security Management Act ("FISMA")

vi. ISO/ IEC 27001

vii. Federal Risk and Authorization Management Program ("FedRamp")

viii. NIST Special Publication 800-34 Revision 1 – "Contingency Planning Guide for Federal Information Systems."

ix. International Organization for Standardization (ISO) 22301 – "Societal security – Business continuity management systems – Requirements."

(f.) "Information Systems" means all computer hardware, databases and data storage systems, computer, data, database and communications networks (other than the Internet), cloud platform, architecture interfaces and firewalls (whether for data, voice, video or other media access, transmission or reception) and other apparatus used to create, store, transmit, exchange or receive information in any form.

(g.) "Multi-Factor Authentication" means authentication through verification of at least two of the following types of authentication factors: (1) knowledge factors, such as a password; (2) possession factors, such as a token or text message on a mobile phone; (3) inherence factors, such as a biometric characteristic; or (4) any other industry standard and commercially accepted authentication factors.

(h.) "Nonpublic Information" includes:

i. Molina's proprietary and/or confidential information;

ii. Personally Identifiable Information as defined under applicable state data security laws, including, without, limitation, "nonpublic personal information," "personal data," "personally identifiable information," "personal information" or any other similar term as defined pursuant to any applicable law; and

iii. Protected Health Information as defined under HIPAA and HITECH.

2. Information Security and Cybersecurity Measures. Provider shall implement, and at all times maintain, appropriate administrative, technical, and physical measures to protect and secure the Information Systems, as well as Nonpublic Information stored thereon, and Molina Information that are accessible to, or held by, Provider. Such measures shall conform to generally recognized industry standards and best practices and shall comply with applicable privacy and data security laws, including implementing and maintaining administrative,

technical, and physical safeguards pursuant to HIPAA, HITECH, and other applicable U.S. federal, state, and local laws.

(a.) Policies, Procedures, and Practices. Provider must have policies, procedures and practices that address its information security and cybersecurity measures, safeguards, and standards, including as applicable, a written information security program, which Molina shall be permitted to audit via written request, and which shall include at least the following:

i. Access Controls. Access controls, including Multi-Factor Authentication, to limit access to the Information Systems and Molina Information accessible to or held by Provider.

ii. Encryption. Use of encryption to protect Molina Information, in transit and at rest, accessible to or held by Provider.

iii. Security. Safeguarding the security of the Information Systems and Molina Information accessible to or held by Provider, which shall include hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, regular (three or more annually) third party vulnerability assessments, physical security controls, and personnel training programs that include phishing recognition and proper data management hygiene.

iv. Software Maintenance. Software maintenance, support, updates, upgrades, third party software components and bug fixes such that the software is, and remains, secure from vulnerabilities in accordance with the applicable Industry Standards.

(b.) Technical Standards. Provider shall comply with the following requirements and technical standards related to network and data security:

i. Network Security. Network security shall conform to generally recognized industry standards and best practices. Generally recognized industry standards include, but are not limited to, the applicable Industry Standards.

ii. Cloud Services Security: If Provider employs cloud technologies, including infrastructure as a service (IaaS), software as a service (SaaS) or platform as a service (PaaS), for any services, Provider shall adopt a "zero-trust architecture" satisfying the requirements described in NIST 800-207 (or any successor cybersecurity framework thereof).

iii. Data Storage. Provider agrees that any and all Molina Information will be stored, processed, and maintained solely on designated target servers or cloud resources. No Molina Information at any time will be processed on or transferred to any portable or laptop computing device or any portable storage medium, unless that device or storage medium is in use as part of the Provider's designated backup and recovery processes and is encrypted in accordance with the requirements set forth herein.

iv. Data Encryption. Provider agrees to store all Molina Information as part of its designated backup and recovery processes in encrypted form, using a commercially

supported encryption solution. Provider further agrees that any and all Molina Information, stored on any portable or laptop computing device or any portable storage medium be likewise encrypted. Encryption solutions will be deployed with no less than a 128-bit key for symmetric encryption, a 1024 (or larger) bit key length for asymmetric encryption, and the Federal Information Processing Standard Publication 140-2 ("FIPS PUB 140-2").

v. Data Transmission. Provider agrees that any and all electronic transmission or exchange of system and application data with Molina and/or any other parties expressly designated by Molina shall take place via secure means (using HTTPS or SFTP or equivalent) and solely in accordance with FIPS PUB 140-2 and the Data Re-Use requirements set forth herein.

vi. Data Re-Use. Provider agrees that any and all Molina Information exchanged shall be used expressly and solely for the purposes enumerated in the Provider Agreement and this section. Data shall not be distributed, repurposed, or shared across other applications, environments, or business units of Provider. Provider further agrees that no Molina Information or data of any kind shall be transmitted, exchanged, or otherwise passed to other affiliates, contractors or interested parties, except on a case-by-case basis as specifically agreed to in advance and in writing by Molina.

3. Business Continuity ("BC") and Disaster Recovery ("DR"). Provider shall have documented procedures in place to ensure continuity of Provider's business operations, including disaster recovery, in the event of an incident that has the potential to impact, degrade, or disrupt Provider's delivery of services to Molina.

(a.) Resilience Questionnaire. Provider shall complete a questionnaire provided by Molina to establish Provider's resilience capabilities.

(b.) BC/DR Plan.

i. Provider's procedures addressing continuity of business operations, including disaster recovery, shall be collected and/or summarized in a documented BC and DR plan or plans in written format ("BC/DR Plan"). The BC/DR Plan shall identify the service level agreement(s) established between Provider and Molina. The BC/DR Plan shall include the following:

a. Notification, escalation and declaration procedures.

b. Roles, responsibilities and contact lists.

c. All Information Systems that support services provided to Molina.

d. Detailed recovery procedures in the event of the loss of people, processes, technology and/or third-parties or any combination thereof providing services to Molina.

e. Recovery procedures in connection with a Cybersecurity Event, including ransomware.

f. Detailed list of resources to recover services to Molina including but not limited to: applications, systems, vital records, locations, personnel, vendors, and other dependencies.

g. Detailed procedures to restore services from a Cybersecurity Event including ransomware.

h. Documented risk assessment which shall address and evaluate the probability and impact of risks to the organization and services provided to Molina. Such risk assessment shall evaluate natural, man-made, political and cybersecurity incidents.

ii. To the extent that Molina Information is held by Provider, Provider shall maintain backups of such Molina Information that are adequately protected from unauthorized alterations or destruction consistent with applicable Industry Standards.

iii. Provider shall develop information technology disaster recovery or systems contingency plans consistent with applicable Industry Standards and in accordance with all applicable laws.

(c.) Notification. Provider shall notify Molina's Chief Information Security Officer by telephone and email (provided herein) as promptly as possible, but not to exceed twenty-four (24) hours, of either of the following:

i. Provider's discovery of any potentially disruptive incident that may impact or interfere with the delivery of services to Molina or that detrimentally affects Provider's Information Systems or Molina's Information.

ii. Provider's activation of business continuity plans. Provider shall provide Molina with regular updates by telephone or email (provided herein) on the situation and actions taken to resolve the issue, until normal services have been resumed.

(d.) BC and DR Testing. For services provided to Molina, Provider shall exercise its BC/DR Plan at least once each calendar year. Provider shall exercise its cybersecurity recovery procedures at least once each calendar year. At the conclusion of the exercise, Provider shall provide Molina a written report in electronic format upon request. At a minimum, the written report shall include the date of the test(s), objectives, participants, a description of activities performed, results of the activities, corrective actions identified, and modifications to plans based on results of the exercise(s).

4. Cybersecurity Events.

(a) Provider agrees to comply with all applicable data protection and privacy laws and regulations. Provider will implement best practices for incident management to identify, contain, respond to, and resolve Cybersecurity Events.

(b) In the event of a Cybersecurity Event that threatens or affects Molina's Information Systems (in connection with Provider having access to such Information Systems); Provider's Information Systems; or Molina Information accessible to or held by Provider,

Provider shall notify Molina's Chief Information Security Officer of such event by telephone and email as provided below (with follow-up notice by mail) as promptly as possible, but in no event later than twenty-four (24) hours from Provider's discovery of the Cybersecurity Event.

i. In the event that Provider makes a ransom or extortion payment in connection with a Cybersecurity Event that involves or may involve Molina Information, Provider shall notify Molina's Chief Information Security Officer (by telephone and email, with follow-up notice by mail) within twenty-four (24) hours following such payment.

ii. Within fifteen (15) days of such a ransom payment that involves or may involve Molina Information, Provider shall provide a written description of the reasons for which the payment was made, a description of alternatives to payment considered, a description of due diligence undertaken to find alternatives to payment, and evidence of all due diligence and sanctions checks performed in compliance with applicable rules and regulations, including those of the Office of Foreign Assets Control.

(c.) 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

(d.) In the event of a Cybersecurity Event, Provider will, at Molina's request, (i) fully cooperate with any investigation concerning the Cybersecurity Event by Molina, (ii) fully cooperate with Molina to comply with applicable law concerning the Cybersecurity Event, including any notification to consumers, and (iii) be liable for any expenses associated with the Cybersecurity Event including without limitation: (a) the cost of any required legal compliance (e.g., notices required by applicable law), and (b) the cost of providing two (2) years of credit monitoring services or other assistance to affected consumers. In no event will Provider serve any notice of or otherwise publicize a Cybersecurity Event involving Molina Information without the prior written consent of Molina.

(e.) Following notification of a Cybersecurity Event, Provider must promptly provide Molina any documentation requested by Molina to complete an investigation, or, upon request by Molina, complete an investigation pursuant to the following requirements:

i. make a determination as to whether a Cybersecurity Event occurred;

ii. assess the nature and scope of the Cybersecurity Event;

iii. identify Molina's Information that may have been involved in the Cybersecurity Event; and

iv. 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 Molina Information.

(f.) Provider must provide Molina the following required information regarding a Cybersecurity Event in electronic form. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Molina concerning the Cybersecurity Event. The information provided to Molina must include at least the following, to the extent known:

i. the date of the Cybersecurity Event;

ii. a description of how the information was exposed, lost, stolen, or breached;

iii. how the Cybersecurity Event was discovered;

iv. whether any lost, stolen, or breached information has been recovered and if so, how this was done;

v. the identity of the source of the Cybersecurity Event;

vi. 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;

vii. a description of the specific types of information accessed or 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;

viii. the period during which the Information System was compromised by the Cybersecurity Event;

ix. The number of total consumers in each State affected by the Cybersecurity Event;

x. 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;

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

xii. 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

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

(g.) 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 Molina's request.

5. Right to Conduct Assessments; Provider Warranty. Provider agrees to fully cooperate with any security risk assessments performed by Molina and/or any designated representative or vendor of Molina. Provider agrees to promptly provide accurate and complete information with respect to such security risk assessments. If Molina performs a due diligence/security risk assessment of Provider, Provider (i) warrants that the services provided pursuant to the Provider Agreement will be in compliance with generally recognized industry standards and as provided in Provider's response to Molina's due diligence/security risk assessment questionnaire; (ii) agrees to inform Molina promptly of any material variation in operations from what was provided in Provider's response to Molina's due diligence/security risk assessment; and (iii) agrees that any material deficiency in operations from those as described in the Provider's response to Molina's due diligence/security risk assessment questionnaire may be deemed a material breach of the Provider Agreement.

6. Other Provisions. Provider acknowledges that there may be other information security and data protection requirements applicable to Provider in the performance of services which may be addressed in an agreement between Molina and Provider but are not contained in this section.

7. Conflicting Provisions. In the event of any conflict between the provisions of this section and any other agreement between Molina and Provider, the stricter of the conflicting provisions will control.

Section 15 Credentialing and recredentialing

The purpose of the Credentialing Program is to assure 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 Relations representative.

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

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

Non-discriminatory credentialing and re-credentialing

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

Type of practitioners credentialed & re-credentialed

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

Practitioner types requiring credentialing include but are not limited to:

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

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

Credentialing turn-around time

Molina fully enrolls/on-boards initial Practitioners within 60 calendar days. The 60 calendar days are 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 60-day turnaround time.

Criteria for participation in the Molina network

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

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

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

of the Professional Review Committee, waive any of the requirements for network participation established pursuant to these policies for good cause, if it is determined such waiver is necessary to meet the needs of Molina and the community it serves. The refusal of Molina to waive any requirement shall not entitle any 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 meet all criteria for initial participation and continued participation in the Molina network. If the Practitioner does not provide this information, the credentialing application will be deemed incomplete, and it will result in an administrative denial or termination from the Molina network. Practitioners who fail to provide proof of meeting these criteria do not have the right to submit an appeal.

- **Application** - Practitioners must submit to Molina a complete credentialing application either from CAQH Pro View or other State mandated Practitioner application. The attestation must be signed within 120 days. Application must include all required attachments.
- **License, Certification or Registration** - Practitioners must hold a current and, valid and license, certification or registration to practice in their specialty in every State in which they will provide care and/or render services for Molina Members. Telemedicine Practitioners are required to be licensed in the State where they are located and the State the Member is located.
- **DEA or CDS Certificate** - Practitioners must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Practitioners must have a DEA or CDS in every State where the Practitioner provides care to Molina Members. If a Practitioner has a pending DEA/CDS certificate and never had any disciplinary action taken related to their DEA and/or CDS 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.
- **Specialty** - Practitioners must only be credentialed in the specialty in which they have adequate education and training. Practitioners must confine their practice to their credentialed area of practice when providing services to Molina Members.
- **Education** - Practitioners must have graduated from an accredited school with a degree in their designated specialty.
    - **Residency Training** - Practitioners must have satisfactorily completed residency training from an accredited program in the specialties in which they are practicing. Molina only recognizes programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be

successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, podiatric residencies are required to be three years in length. If the podiatrist has not completed a three year residency or is not board certified, the podiatrist must have five years of work history practicing podiatry.

- **Fellowship Training** - Fellowship training is verified when a practitioner will be advertised in the directory in their fellowship specialty. Molina only recognizes fellowship programs accredited by ACGME, AOA, CFPC, and CODA.

- **Board Certification** - Board certification in the specialty in which the Practitioner is practicing but not required. Initial applicants who are not board certified will be considered for participation if they have satisfactorily completed residency training from an accredited program in the specialty in which they are practicing. Molina recognizes certification only from the following Boards:
  - American Board of Physicians
  - 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
  - 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 training from an accredited program are only eligible to be considered for participation as a general Practitioner in the Molina network. To be eligible, the Practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history. Molina will consider allowing a Practitioner who is/was board certified and/or residency trained in a specialty other than primary care to participate as a general Practitioner, if the practitioner is applying to participate as a Primary Care Physician (PCP), or as an Urgent Care Practitioner or Wound Care. General Practitioners providing only wound care services do not require five years of work history as a PCP.

- **Nurse Practitioners & Physician Assistants** – In certain circumstances, Molina may credential a practitioner who is not licensed to practice independently. In these instances, the practitioner providing the supervision and/or oversight must also be contracted and credentialed with Molina.

- **Work History** - Practitioners must supply the most recent five years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six months, the Practitioner must clarify the gap verbally or in writing. The organization documents a verbal clarification

in the Practitioner's credentialing file. If the gap in employment exceeds one year, the Practitioner must clarify the gap in writing.

- **Malpractice History** - Practitioners 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** – Practitioners must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Practitioners must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application 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. At the time of initial application, the Practitioner must not have any pending or open investigations from any state or governmental professional disciplinary body. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.[3]

- **Medicare, Medicaid and other Sanctions and Exclusions** – Practitioners 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. Practitioners 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. Practitioners 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.

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.

- **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** – Practitioners must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the Practitioner's activities on Molina's behalf. Practitioners maintaining coverage under federal tort or self-insured policies are not required to include amounts of coverage on their application for professional or medical malpractice insurance.
- **Inability to Perform** – Practitioners must disclose any inability to perform essential functions of a practitioner in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Lack of Present Illegal Drug Use** – Practitioners must disclose if they are currently using any illegal drugs/substances.
- **Criminal Convictions** – Practitioners must disclose if they have ever had any of the following;
    - Criminal convictions, including any convictions, guilty pleas or adjudicated pretrial diversions for crimes against person such as murder, rape, assault and other similar crimes.
    - Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes.
    - Any crime that placed the Medicaid or Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
    - Any crime that would result in mandatory exclusion under section 1128 of the Social Security Act.
    - Any crime related to fraud, kickbacks, health care fraud, claims for excessive charges, unnecessary services or services which fail to meet professionally recognized standards of health care, patient abuse or neglect, controlled substances, or similar crimes.

  At the time of credentialing, Practitioners must not have any pending criminal charges in the categories listed above.
- **Loss or Limitations of Clinical Privileges** – At initial credentialing, Practitioners must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At re-credentialing, Practitioners 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** - Practitioners 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 if 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 actions, sanctions or exclusions. Molina is not required to reveal the source of information if the information is obtained to meet organization credentialing verification requirements or if disclosure is prohibited by Law.

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

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

- Their requirement to submit a written response within ten calendar days of receiving notification from Molina
- In their response, the Practitioner must explain the discrepancy, may correct any erroneous information and may provide any proof that is available
- The Practitioner's response must be sent to:

Molina Healthcare, Inc.
Attention: Credentialing Director
22522 – 29th Drive SE, #L-210
PO Box 4004
Bothell, WA 98041

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

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

Practitioner's right to review information submitted to support their credentialing application

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

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

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

Practitioner's right to be informed of application status

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

Notification of credentialing decisions

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

Recredentialing

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

Excluded Providers

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

Pursuant to section 1128 of the SSA, Molina and its Subcontractors may not subcontract with an excluded Provider/person. Molina and its Subcontractors shall terminate Subcontracts immediately when Molina and its Subcontractors become aware of such excluded Provider/person or when Molina and its Subcontractors receive notice. Molina and its Subcontractors

certify that neither it nor its Provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency. Where Molina and its Subcontractors are unable to certify any of the statements in this certification, Molina and its Subcontractors shall attach a written explanation to this Agreement.

Ongoing monitoring of sanctions and exclusions

Molina monitors the following agencies for Practitioner sanctions and exclusions between re-credentialing cycles for all Practitioner types and takes appropriate action against Practitioners when instances of poor quality are identified. If a Molina Practitioner is found to be sanctioned or excluded, the Practitioner's contract will be immediately 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).
- **The OIG High Risk List** – Monitor for individuals or facilities who refused to enter into a Corporate Integrity Agreement (CIA) with the federal government on or after October 1, 2018.
- **Medicare Exclusion Database (MED)** - Monitor for Medicare exclusions through the Centers for Medicare & Medicaid Services (CMS) MED online application site.
- **Medicare Preclusion List** – Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- **National Practitioner Database** - Molina enrolls all credentialed practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- **System for Award Management (SAM)** - Monitor for Practitioners sanctioned by SAM.

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

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

Effective 07/01/2025, Molina will monitor the timely renewal of healthcare licenses for all Practitioner types. In the event a Practitioner does not renew their state license prior to the expiration date, Molina may take action up to and including payment suspension for dates of service on or after license expiration or termination from applicable Molina provider networks.

Provider appeal rights

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

Section 16 Delegation

Delegation is a process that gives another entity the ability to perform specific functions on behalf of Molina. Molina may delegate:

1. Utilization management
2. Credentialing and recredentialing
3. Claims
4. Complex case management
5. CMS Preclusion List monitoring
6. Other clinical and administrative functions

When Molina delegates any clinical or administrative functions, Molina remains responsible to external regulatory agencies and other entities for the performance of the delegated activities, including functions that may be sub-delegated. To become a delegate, the Provider/Accountable Care Organization (ACO)/vendor must be in compliance with Molina's established delegation criteria and standards. Molina's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements. To remain a delegate, the Provider/ACO/vendor must maintain compliance with Molina's standards and best practices.

Disease management

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

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

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

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

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

Credentialing

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

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

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

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

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

Delegation reporting requirements

Delegated entities contracted with Molina must submit monthly, quarterly reports, and adhoc reports. Such reports will be determined by the function(s) delegated and reviewed by Molina Delegation Oversight staff for compliance with performance expectations within the timeline and format indicated by Molina.

Corrective action plans and revocation of delegated activities

If it is determined that the delegate is out of compliance with Molina's guidelines or regulatory requirements, Molina may require the delegate to develop a corrective action plan designed to bring the delegate into compliance. Molina may also revoke delegated activities if it is determined that the delegate cannot achieve compliance or if Molina determines that is the best course of action.

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

Section 17 Appeals and grievance process

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

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

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

Definitions

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

Appeal: A request for review of an Adverse Benefit Determination.

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

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

Grievance: An expression of dissatisfaction about any matter other than an Action. Possible subjects for Grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the member's rights.

Second opinion

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

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

Member grievance process:

If a Member is unhappy with the service from Molina or Providers contracted with Molina, they may file a grievance by contacting Member Services toll-free at (855) 882-3901 (TTY: 711). They can also write to us at:

Attn: Molina Healthcare of South Carolina
C/O Firstsource
PO Box 182273
Chattanooga, TN 37422
Fax Number: (877) 823-5961

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

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

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

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

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

Grievance timelines

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

All grievances are resolved within 90 calendar days.

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

Appeals

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

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

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

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

why the delay is in their best interest. If Molina extends the time frame, the letter will also include information about the Member's right to file a grievance about extending the time frame.

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

Standard appeals process and timeline

Standard appeals may be submitted orally or in writing. Standard appeals must be filed within 90 calendar days from the date of the notice of adverse benefit determination and may be submitted to:

Attn: Molina Healthcare of South Carolina
C/O Firstsource
PO Box 182273
Chattanooga, TN 37422
Telephone Number: (855) 882-3901 (TTY: 711)
Fax Number: (877) 823-5961

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

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

Expedited appeals process and timeline

Expedited appeals are available when following the standard appeals time frame could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. Expedited appeals may be submitted orally or in writing. Expedited appeals can be filed within 60 calendar days from the date of notice of adverse benefit determination. Submit requests to:

Molina Healthcare of South Carolina
C/O Firstsource
PO Box 182273
Chattanooga, TN 37422
Telephone Number: (855) 882-3901 (TTY: 711)
Fax Number: (877) 823-5961

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

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

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

State Fair Hearing

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

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

Continuation of benefits

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

Provider claim dispute/claim re-determination request

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

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

These requests shall be classified as a Claims Disputes/Adjustment and be submitted via the following methods:

- Availity Essentials portal (preferred method)
  Availity.com/providers
- U.S. Mail:
  Attn: Molina Healthcare of South Carolina
  C/O Firstsource
  1232 Premier Dr., Suite 100,
  Chattanooga, TN 37421
- Fax: (877) 901-8182

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

Please note that Molina does not offer second level appeals.

Reporting

Grievance and appeal trends are reported to Quality Improvement and Health Outcome Committee quarterly. This trend report includes a quantitative review of trends, qualitative or barriers analysis, and identification of interventions that address key drivers. An annual evaluation of grievance and appeal analysis is then completed and presented to Quality Improvement and Health Outcome Committee for evaluation. If required by the state or CMS, reporting is submitted to the Appropriate Agency as needed.

Appendix

Molina forms and materials

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

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

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

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

Transportation broker listing and contact information

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

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

Toll-Free Phone Numbers:

(866) 910-7688
(866) 445-6860
(866) 445-9954

For more information on ModivCare, visit MyModivcare.com/members/sc

34964OTHMDSCEN
260821