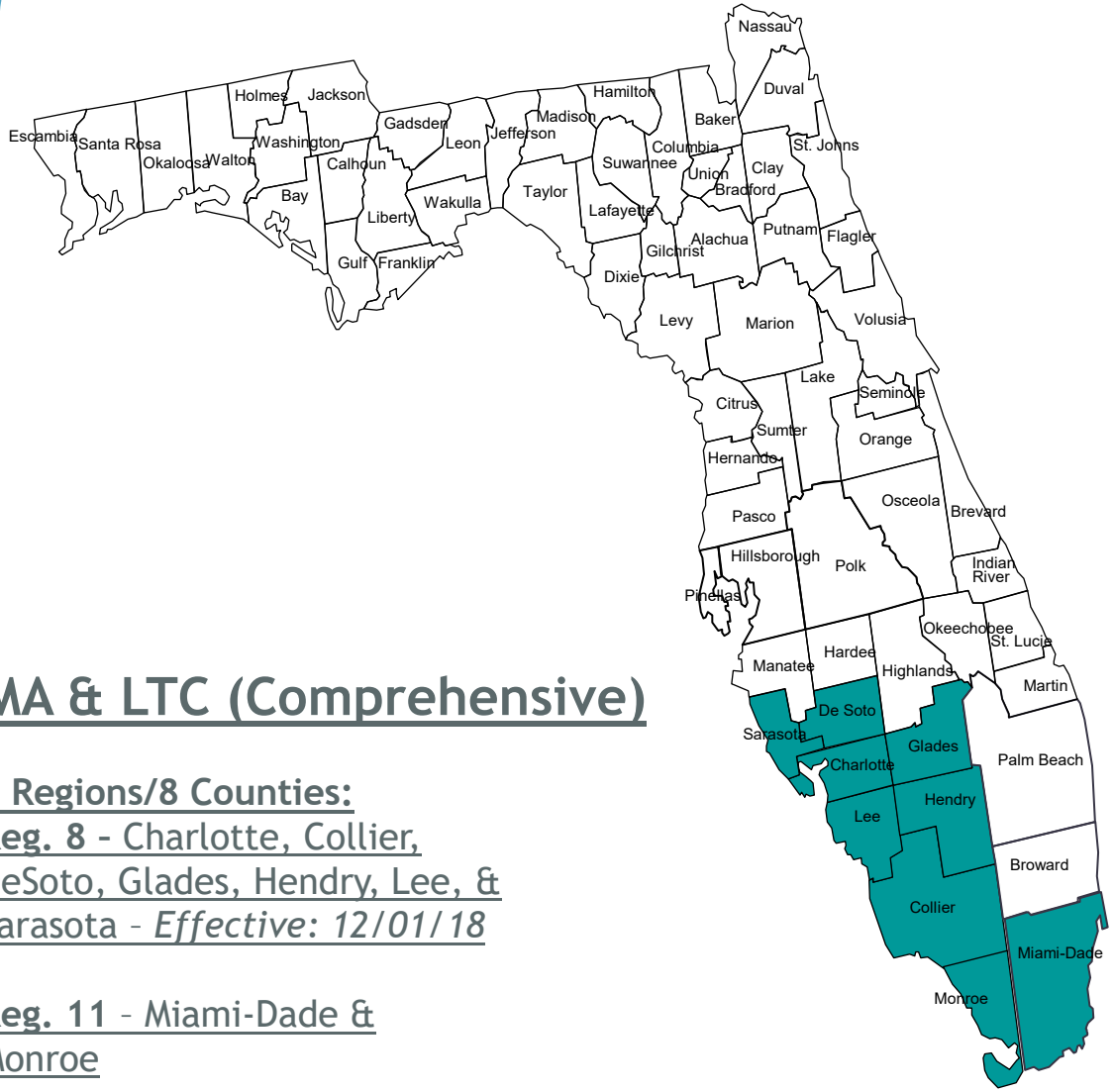
Molina Healthcare Provider Orientation

Product Service Areas



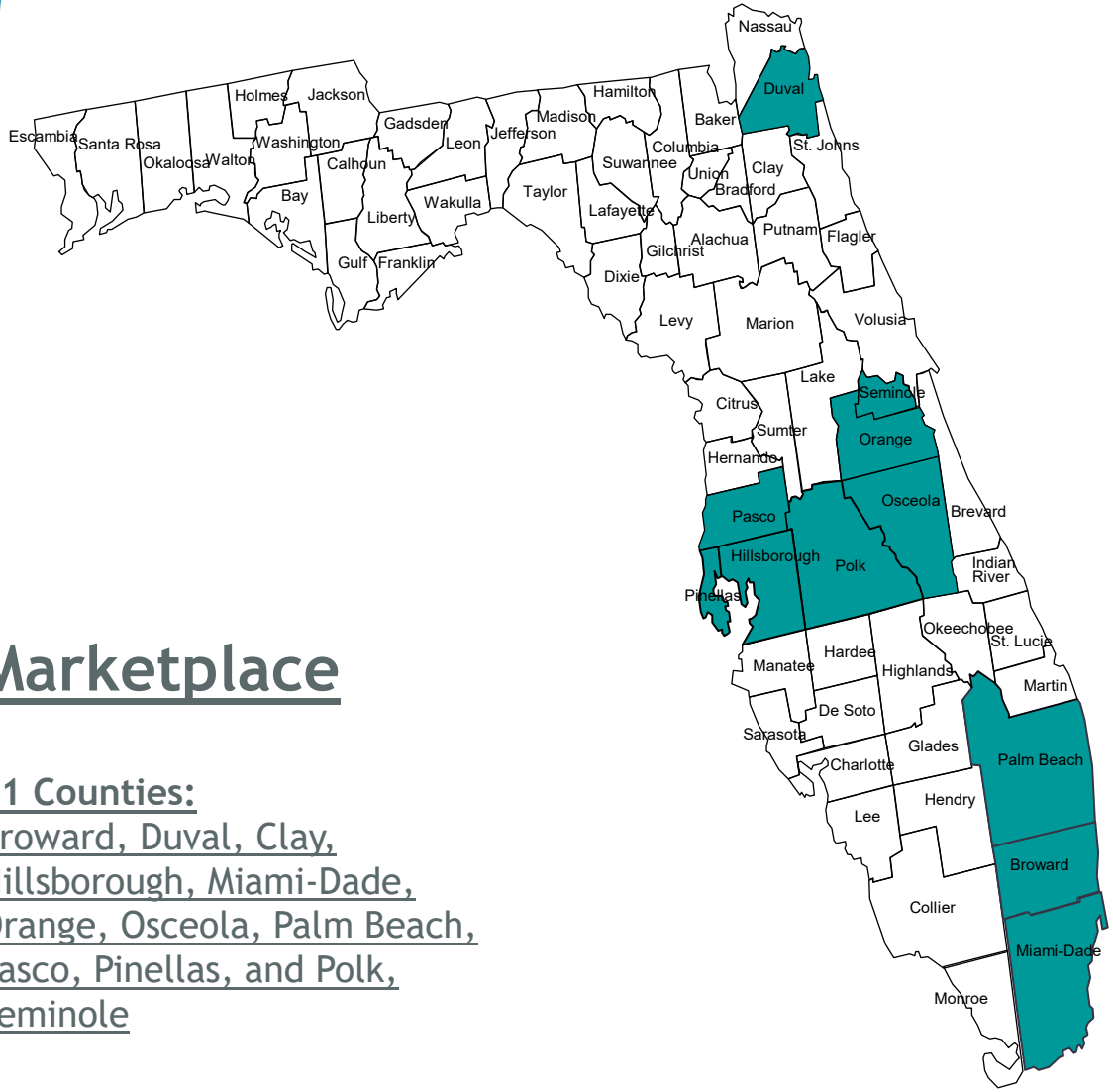
MMA & LTC (Comprehensive)

2 Regions/8 Counties:

Reg. 8 - Charlotte, Collier, DeSoto, Glades, Hendry, Lee, & Sarasota – *Effective: 12/01/18*

Reg. 11 – Miami-Dade & Monroe

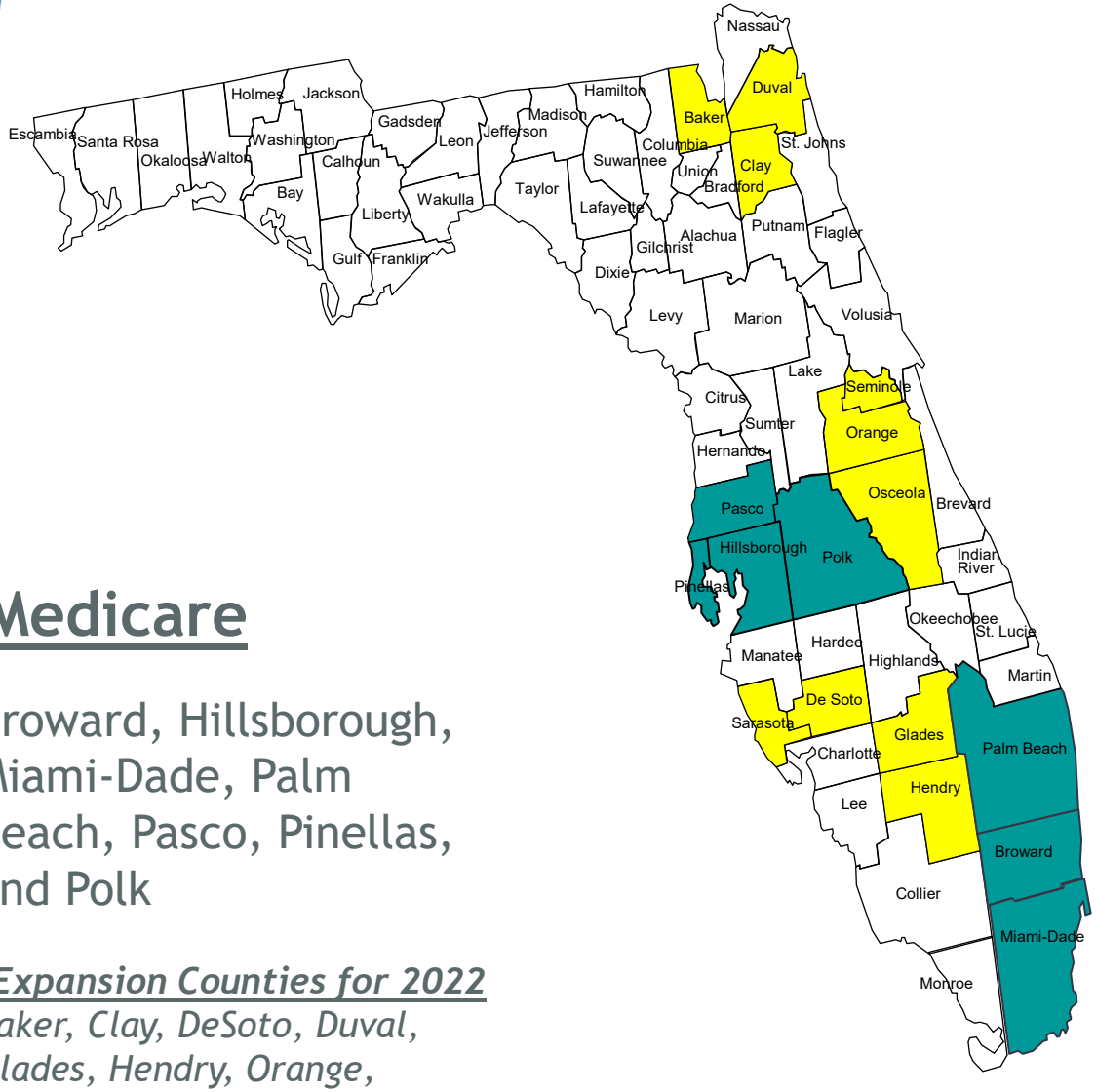
Product Service Areas



Marketplace

11 Counties:
Broward, Duval, Clay, Hillsborough, Miami-Dade, Orange, Osceola, Palm Beach, Pasco, Pinellas, and Polk, Seminole

Product Service Areas



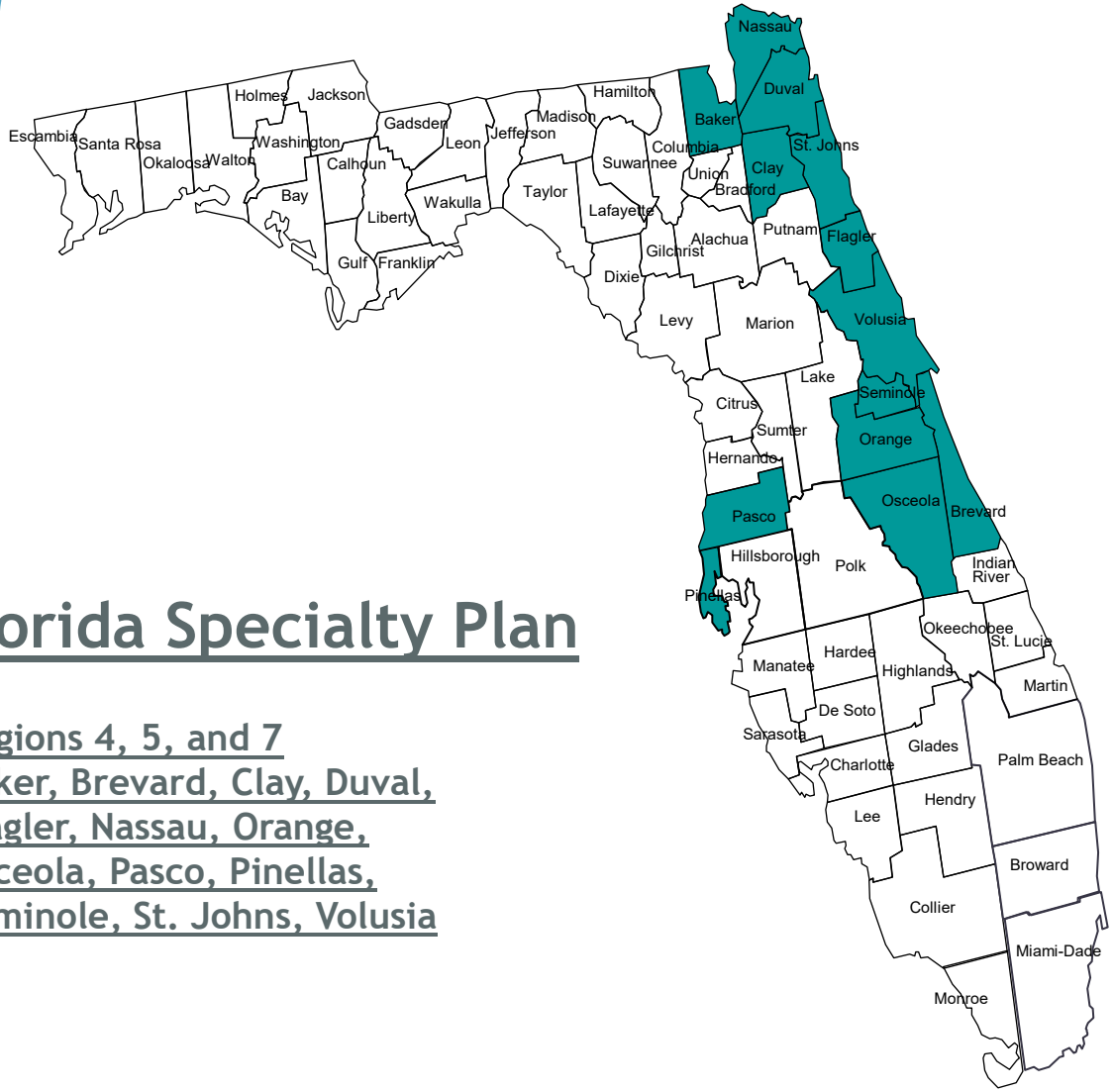
Medicare

Broward, Hillsborough, Miami-Dade, Palm Beach, Pasco, Pinellas, and Polk

Expansion Counties for 2022

Baker, Clay, DeSoto, Duval, Glades, Hendry, Orange, Osceola, Sarasota, Seminole

Product Service Areas

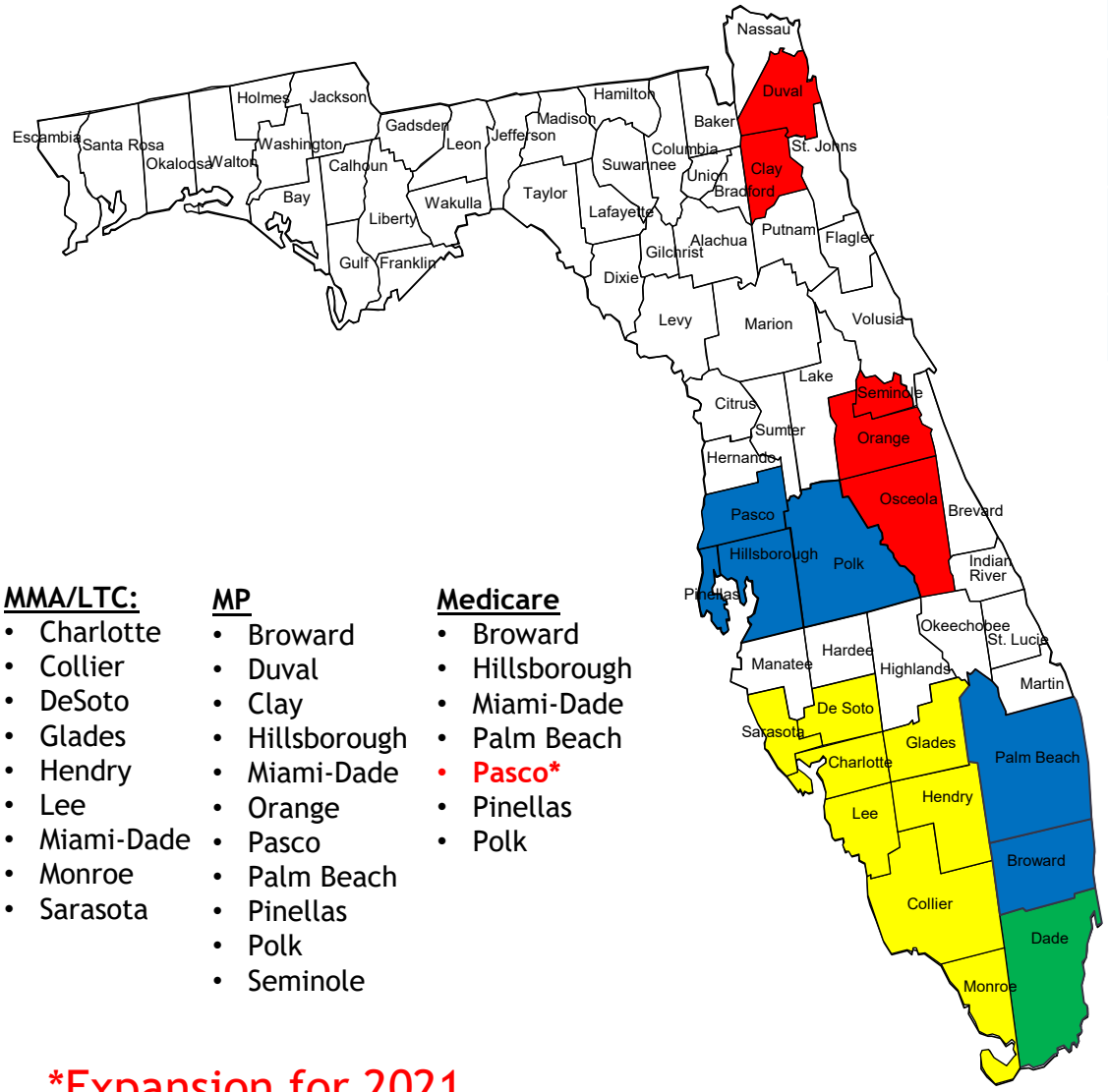


Florida Specialty Plan

Regions 4, 5, and 7
Baker, Brevard, Clay, Duval, Flagler, Nassau, Orange, Osceola, Pasco, Pinellas, Seminole, St. Johns, Volusia

Product Service Areas - Statewide

MFL Product	Color
ALL Products	Green
Medicaid & LTC	Yellow
Medicare & Marketplace	Blue
Marketplace	Red



MMA/LTC:

- Charlotte
- Collier
- DeSoto
- Glades
- Hendry
- Lee
- Miami-Dade
- Monroe
- Sarasota

MP

- Broward
- Duval
- Clay
- Hillsborough
- Miami-Dade
- Orange
- Pasco
- Palm Beach
- Pinellas
- Polk
- Seminole

Medicare

- Broward
- Hillsborough
- Miami-Dade
- Palm Beach
- **Pasco***
- Pinellas
- Polk

*Expansion for 2021

Overview

Medicaid is the medical assistance program authorized by Title XIX of the Social Security Act, 42U.S.C. §1396 et seq., and regulations thereunder, as administered in the State of Florida by the Agency for Healthcare Administration under s. 409.901 et seq., F.S. It is the state and federal system of health insurance that provides health coverage for eligible children, seniors, disabled adults and pregnant women.

The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, F.S.) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. This program is referred to as statewide Medicaid managed care (SMMC) and originally included two programs: one for medical assistance (MMA) and one for long-term care (LTC).

MOLINA® HEALTHCARE

SMMC Plan Types

Managed Medical Assistance Plan

Provides Managed Medical Assistance services to eligible recipients.

This plan type cannot provide services to recipients who are eligible for Long-term Care services.

Long-Term Care Plus Plan

Provides Managed Medical Assistance (MMA) services and Long-Term Care services to recipients enrolled in the Long-Term Care program.

Comprehensive Plan

Provides Managed Medical Assistance services and Long-Term Care services to eligible recipients.

Specialty Plan

Provides Managed Medical Assistance services to eligible recipients who are defined as a specialty population.

Dental Plan

Provides preventive and therapeutic dental services to all recipients in managed care and all and fully eligible fee-for-service individuals.

MOLINA® HEALTHCARE

Magellan Acquisition 2021

Effective September 1, 2021, Molina Healthcare of Florida (MFL) is acquiring Magellan Complete Care for the Medicaid (MMA), line of business. Magellan Complete Care of Florida (MCC of FL) is a Medicaid specialty plan and is part of the Statewide Medicaid Managed Care program specializing in the care of those with Serious Mental Illness (SMI). Members are eligible for Medicaid and have been diagnosed with a Serious Mental Illness.

MOLINA® HEALTHCARE

Magellan Acquisition 2021

MS2

Molina Healthcare's Serious Mental Illness (SMI) Specialty Plan is for Medicaid recipients ages six(6) and older who are diagnosed with or in treatment for a serious mental illness. The SMI specialty plan is available in Regions 4,5, and 7.

SMI members are considered members who are diagnosed with Schizophrenia, Schizoaffective Disorder, Delusional Disorder, Bipolar Disorder, Major Depression or Obsessive-Compulsive Disorder (OCD); and are treated with a medication commonly used to treat a disorder listed above.

MOLINA HEALTHCARE

Slide 10

MS2 Marshall, Shaun, 7/9/2021

Magellan Acquisition 2021

Effective September 1, 2021

- MCC of FL providers will have contract terms and reimbursement rates in coordination with MFL Contract Policies.
- MCC of FL (SMI) Members will be Molina Members, and shall receive new MFL Member ID Cards reflecting "Florida SMI Specialty Plan"
- Provider Network Management Contacts for MFL:
  - Phone: (855) 322-4076
  - Email: MFLProviderNetworking@Molinahealthcare.com
- MCC of FL providers will work with MFL Healthcare Services staff to coordinate services for Florida SMI Specialty Plan Members
- All MCC of FL provider materials will now be integrated with Molina up to, including, but not limited to:
  - Provider Manuals/Handbooks and other materials
  - Phone Numbers, Websites and Portals

MOLINA HEALTHCARE

Magellan Acquisition 2021- Claim Submission Dates to Remember

MS1

Dates of Service:

August 31st, 2021 and Prior

Claims will be submitted to MCC until 12/31/21.

Date of service on and after

September 1st, 2021

Submit claims to Molina Healthcare

Slide 12

MS1 Add 3rd box

Marshall, Shaun, 7/9/2021

Covered Services*

**For more information Molina's Covered Services and criteria, please refer to the Provider Handbook or contact Molina Healthcare.*

Advanced Registered Nurse Practitioner Services	Medical Supplies, Equipment, Prostheses and Orthoses
Ambulatory Surgical Treatment Center Services	Mental Health Services
Birthing Center Services	Nursing Care
Chiropractor Services	Optical Services and Supplies
Early Periodic Screening Diagnosis and Treatment Services for Recipients Under Age 21	Optometrist Services
Emergency Services	Physical, Occupational, Respiratory, and Speech Therapy
Family Planning Services and Supplies	Physician Services, including physician assistant services
Healthy Start Services	Podiatric Services
Hearing Services	Prescription Drugs
Home Health Agency Services	Renal Dialysis Services
Hospice Services	Respiratory Equipment and Supplies
Hospital Inpatient Services	Rural Health Clinic Services
Hospital Outpatient Services	Substance Abuse Treatment Services
Laboratory and Imaging Services	Transportation to Access Covered Services

MOLINA HEALTHCARE

Expanded Benefits*

**For more information Molina's Expanded Benefits and criteria, please refer to the Provider Handbook or contact Molina Healthcare.*

MMA	LTC
Over-the-Counter Benefit	Assisted Living Facility/Adult Family Care Home - Bed Hold Days
Occupational Therapy	Transition Assistance - Nursing Facility to Community Setting
Physical Therapy	
Hearing Services	
Vision Services	
Prenatal Services	**BEHAVIORAL**
Respiratory Therapy	Intensive Outpatient Treatment
Speech Therapy	Computerized Cognitive Behavioral Analysis
Primary Care Services Newborn Circumcision	Therapy/Psychotherapy (Individual/Family)
CVS Discount Program	Therapy/Psychotherapy (Group)
Durable Medical Equipment/Supplies	**SMI**
Home Delivered Meals - Post-Facility Discharge (Hospital or Nursing Facility)	Collaborative Care
	Circumcision (newborns only)
	Chiropractic Services
Home Delivered Meals – Disaster Preparedness/Relief	Behavioral Health Assessment/Evaluation Services
Home Health Nursing/Aide Services	Behavioral Health Day Services/Day Treatment
Housing Assistance	Behavioral Health Medical Services (e.g. medication management, drug screening, etc.)
Meals - Non-emergency Transportation Day-Trips	Behavioral Health Psychosocial Rehabilitation
Non-Emergency Transportation - Non-Medical Purposes	Behavioral Health Screening Services
Doula Services	Behavioral Health Group Therapy
Nutritional Counseling	Hearing Services
Vaccine - TDaP	Individual/Family Therapy
Vaccine - Influenza	Home Health Visits – enhanced for non-pregnant adults
Vaccine - Shingles	Intensive Outpatient Therapy Services
Vaccine - Pneumonia	Primary Care Visits – enhanced for non-pregnant adults
Waived Copayments	Respiratory Services
Acupuncture	Speech Therapy
Chiropractic Services	Substance Abuse Treatment or Detoxification Services (Outpatient)
Massage Therapy	

In-Lieu Of Services*

"In lieu of services" are alternative services in a setting that are not included in the state plan or otherwise covered by the contract but are medically appropriate, cost-effective substitutes for state plan services included within a contract.

For more information Molina's In-Lieu Of Services and criteria, for MMA/LTC and SMI members please refer to the Provider Handbook or contact Molina Healthcare.

MOLINA HEALTHCARE

Transportation

Molina Healthcare offers its members access to non-emergency transportation through Access2Care Transportation.

To make an appointment for a transportation service, contact A2C Transportation's reservation line at:

- MMA/LTC: 1(888) 298-4781 - 8am – 7pm ET
- Medicare: 1(888) 276-4781 - 8am – 8pm ET

MOLINA® HEALTHCARE

Preferred Drug List (PDL)

Molina covers those drugs and dosage forms listed in the Agency For Healthcare Administration's Medicaid Preferred Drug List (PDL) below:

http://ahca.myflorida.com/Medicaid/Prescribed_Drug/pharm_thera/fmpdl.shtml

Molina Medicare Preferred Drug List (PDL):

https://www.molinahealthcare.com/providers/common/medicare/~/media/Molina/PublicWebsite/PDF/members/fl/en-us/Medicare/FL-2021-SNP-FORMULARY-ENES-508.pdf

Molina Marketplace Preferred Drug List (PDL):

https://www.molinamarketplace.com/marketplace/fl/en-us/-/media/Molina/PublicWebsite/PDF/members/fl/en-us/Marketplace/formulary-2021.pdf

Molina Pharmacy Prior Authorization Form:
https://www.molinahealthcare.com/providers/fl/PDF/Medicaid/forms_FL_PARequestForm.pdf

MOLINA HEALTHCARE

Timely Access Standards

Appointments for ***Urgent*** care services shall be provided:

- Within forty-eight (48) hours of a request for medical or behavioral health care services that ***do not*** require prior authorization.

- Within ninety-six (96) hours of a request for medical or behavioral health care services that ***do*** require prior authorization.

Appointments for ***Non-Urgent*** care services shall be provided:

- Within seven (7) days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment.
- Within fourteen (14) days for initial outpatient behavioral health treatment.
- Within fourteen (14) days of a request for ancillary services for the diagnosis or treatment of injury, illness, or other health condition.
- Within thirty (30) days of a request for a primary care appointment.
- Within sixty (60) days of a request for a specialist appointment after the appropriate referral is received by the specialist.

MOLINA® HEALTHCARE

In-Office Labs

Molina allows only specific laboratory tests in the physician's office. All other medically necessary laboratory testing must be directed to Quest by the ordering physician.

For a list of approved in-office tests, visit Molina's website at www.molinahealthcare.com

This list includes most tests currently performed in the office by our network providers, and tests generally considered essential ("stat") for immediate diagnosis and treatment. Claims for tests performed in the physician office, but not on Molina's list of allowed in-office laboratory tests will be denied.

For more information about In-Network Laboratory Providers, please consult the Molina Provider Directory found at: (https://providersearch.molinahealthcare.com/).

For testing available through In-Network Laboratory Providers, or for a list of In-Network Laboratory Provider patient services centers, please reach out to the In-Network Laboratory Provider.

Molina's preferred provider of laboratory services is Quest Diagnostics.

Quest Diagnostics
866-MYQUEST (866-697-8378)
www.questdiagnostics.com

MOLINA HEALTHCARE

Elective Services

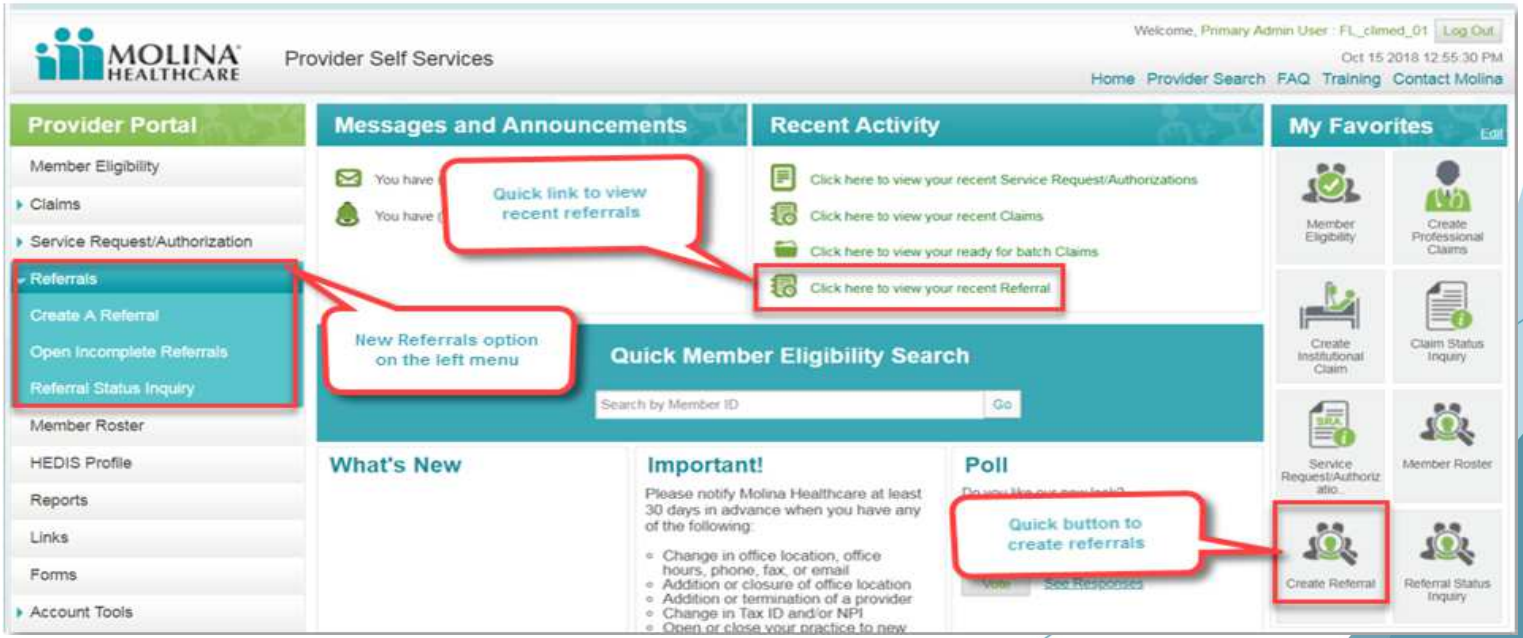
Molina Healthcare requires Prior Authorization for all elective services in a hospital setting for all Lines of Business.

MOLINA HEALTHCARE

In-Network Specialist Referrals

Florida providers are required to submit referrals to in-network specialists. PCPs may use *Molina's Paper Referral*, an *Electronic Referral*, or *Internal Referral Form (i.e.: script)*.

The electronic forms will be available on the web for our providers. Referral details will also be available for our members on the My Molina member portal and Health in Hand app. PCPs may electronically edit the Expiration Date and Number of Visits as needed.



In-Network Specialist Referrals

Referrals are *not* required for visits to providers with the following specialties - ***Obstetrics and Gynecology, Dermatology, Chiropractic, and Podiatry***. Members may access these specialties directly.

Please Note: The referral requirement does not affect Molina's Prior Authorization guidelines. Therefore, services that require prior authorization will continue to require clinical review and prior approval by Molina, and will not be reimbursed without a referral.

Specialists should continue to submit requests directly to Molina for services that require Prior Authorization, and not direct members back to their PCP's to submit the authorization requests on behalf of the specialists. ***Ex.: Non-Par Specialist referrals will still require Prior Authorization***.

MOLINA® HEALTHCARE

Referrals & Authorization

Providers should send requests for prior authorizations to the Utilization Management Department using the Molina Healthcare of Florida Prior Authorization Guide and Service Request Form included in your Welcome Kit, and also available on our website, at:

https://www.molinahealthcare.com/providers/fl/marketplace/forms/Pages/fuf.aspx

Service Request Forms may be faxed to the Utilization Management Department to the numbers listed below, or submitted via our Provider Web Portal.

Web Portal :
https://provider.molinahealthcare.com/Provider/Login

Medicaid/Marketplace Fax: (866)-440-9791
Medicare Fax: (866) 472-9509

MOLINA HEALTHCARE

Medical Necessity

Pursuant to FS 409.9131 (2) (b)“Medical necessity” or “medically necessary” means any goods or services necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice.

For purposes of determining Medicaid reimbursement, the agency (AHCA) is the final arbiter of medical necessity. In making determinations of medical necessity, the agency must, to the maximum extent possible, use a physician in active practice, either employed by or under contract with the agency, of the same specialty or subspecialty as the physician under review. Such determination must be based upon the information available at the time the goods or services were provided.

MOLINA® HEALTHCARE

Referrals & Authorization

Urgent Vs. Non-Urgent Requests

Urgency is reserved for those tests required to prevent serious deterioration in the member's health or ability to regain maximum function. Urgent status may also be appropriate if, in the opinion of the ordering provider with knowledge of the member's medical condition, delay would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. Requests outside of this definition should be submitted as routine/non-urgent.

MOLINA® HEALTHCARE

Referrals & Authorization

Urgent Vs. Non-Urgent Requests

Molina Healthcare of Florida will process all “non-urgent” requests in no more than 7 calendar days of the initial request. “Urgent” requests will be processed within 72 hours of the initial request.

Providers who request prior authorization approval for patient services and/or procedures can request to review the criteria used to make the final decision.

Providers may request to speak to the Medical Director who made the determination to approve or deny the service request.

MOLINA® HEALTHCARE

Referrals & Authorization

Supporting Documentation

Authorization for elective services should be requested with supporting clinical documentation at least 7 days prior to the date of the requested service. Authorization for emergent services should be requested within one business day. Information generally required to support decision making includes:

- Current (up to 6 months), adequate patient history related to the requested services

- Physical examination that addresses the problem

- Lab or radiology results to support the request (Including previous MRI, CT, Lab or X-ray report/results)

- PCP or Specialist progress notes, consultations and/or Plan of Care (PoC)

- Any other information or data specific to the request

MOLINA® HEALTHCARE

Referrals & Authorization

Supporting Documentation

All chart notes relevant to the prescription request **must** be submitted along with the completed Prior Authorization form to avoid delays in processing due to insufficient information or lack thereof.

Please Note: If you receive an Authorization request denial for "*no chart notes submitted*", please attempt to resubmit your request instead of submitting an appeal, as proper clinical review did not

MOLINA HEALTHCARE

Emergency Services

Emergency services are covered twenty-four (24) hours a day, seven (7) days a week, three-hundred sixty-five (365) days a year, for all Members experiencing an emergency medical situation. **No authorization is required.**

When a Member presents at a hospital seeking emergency services and care, the determination that an emergency medical condition exists shall be made, for the purposes of treatment, by a physician of the hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a hospital physician.

MOLINA® HEALTHCARE

EMR Access

Molina Healthcare strives to improve HEDIS scores year around through the collection and reporting of data. To achieve high HEDIS scores, the collection of medical records must occur multiple times of the years. Molina is interested in developing a relationship with provider groups by utilizing EMR Remove Access method to efficiently retrieve the necessary records to met HEDIS requirements.

Benefits from EMR Remote Access:

- Reduction in time and office resources
- Removing the need for multiple outreaches from our team to yours
- Mitigating COVID-19 risks associated with going on-site

For more information, please contact your Intervention specialist or HEDIS Specialist at HEDIS: RegionDHEDIS@MolinaHealthCare.Com.

MOLINA HEALTHCARE

Telehealth Provider Requirements

All providers that provide Telehealth services must comply with the following:

- Fraud, Waste & Abuse Policies & Procedures
- Medical Record Documentation Requirements
- Audio/Visual (A/V) Equipment must provider real-time 2-way A/V live communication.
  - Phone Calls, Faxes, Chart Reviews do not count
- Must comply with HIPAA and Privacy Laws
- Equipment and operations must comply with the technical safeguards in ***45CFR 164.312***
- Provider Training on Telehealth Requirements

All Molina providers that wish to provide this service must attest that they have reviewed and meet these requirements in order to offer Virtual Health.

The Telehealth Attestation is found on Molina's website at: http://www.molinahealthcare.com

Preferred Health Management –
Assisted Living Services Vendor

Effective April 1, 2019 Molina Healthcare has partnered with Preferred Health Management (PHM) to manage, credential, and pay claims for Assisted Living Facilities for our Long-Term Care and Comprehensive (MMA & LTC) members.

Payments made by PHM will be available for pick-up on the 1st of the month at:

Preferred Health Management
7480 Bird Rd
Ste: 820
Miami, FL 33155

or

Sent via Direct Deposit or Postal Delivery (Direct Deposit or Postal Delivery of payments must be coordinated directly with PHM).

Also, please remember that any and all services requested still must adhere to Molina's Prior Authorization guidelines.

Assisted Living Services - Billing Tips

- Place of Service for ALF is 13
- Billing code is T2030
- Diagnosis code is R68.89
- Dates of service should not be spanned. Always bill the same date in the from & to fields
- Units must match the number of days in month, or the number of days in the facility

Skilled Nursing Facility – Billing Tips

SNF's should bill in accordance with Florida Medicaid guidelines.

- Revenue Code 0101- Long Term Care Days
- Revenue Code 0185 - Hospital Leave Days (Bed Hold Days)
- Revenue Code 0182 – Home Leave Days (Therapeutic bed-hold days)

Coastal Care Services –
Home Health, Home Infusion, DME Vendor

Effective July 1, 2019 Coastal Care Services will manage, credential, and pay claims for DME, Home Health, and Home Infusion services for Molina Healthcare's Medicaid, Medicare, and MP members.

To bill for Home Health, Durable Medical Equipment, or Home Infusion services, claims should be sent directly to Coastal Care Services. *Any claims for the above services will be denied by Molina Healthcare and redirected to Coastal Care Services.

Coastal Care Services is not used for Long-Term Care authorizations or claims.

**Please ensure that any and all services requested adhere to Molina's Prior Authorization guidelines.*

Durable Medical Equipment – Tips

All DME, medical supplies, and orthotics and prosthetic devices must be:

- Medically necessary, and
- Functionally appropriate for the individual recipient, and
- Adequate for the intended medical purpose, and
- For conventional use, and
- For the exclusive use of the recipient.

DME items requested or supplied must not duplicate or perform the same function as other DME equipment or medical supplies currently in the recipient's possession.

Medical necessity documentation must specify the type, quantity, and frequency of need for consumable medical supplies prescribed by the recipient's treating physician or the treating physician's prescribing ARNP or Physician Assistant.

What is EVV?

Electronic Visit Verification (EVV) electronically captures:

- That a home care agency employee provided the agreed-upon point-of-care service
- The time that a visit began and ended
- The individual who received the service
- The date and location of the provided service

The purpose behind the EVV mandate is to track home health providers and ensure the visits they're reporting to CMS are actually taking place, that patients are getting the care they require, and that Medicaid is being accurately billed.

Other benefits of EVV technology solutions include the ability to:

- Reduce missed visits and late starts
- Improve patient care and client outcomes
- Reduce paper documentation traditionally associated with visit verification
- Increase productivity and efficiency among staff members
- Reduce costs associated with the use of multiple software products

EVV Mandate

Section 12006(a) of the 21st Century Cures Act mandates that Florida implements Electronic Visit Verification (EVV) for all providers enrolled directly in the SMMC program that furnish Home Health services (Home Health visits, Private Duty Nursing, and Personal Care Services) to recipients through the fee-for-service delivery system in accordance with Section 409.9132,(F.S.).

Molina has partnered with HHAeXchange as our EVV vendor.

Long-Term Care (LTC) Home Health and Personal Care providers are required to use EVV.

HHAeXchange Portal

- Accept service authorizations within the portal
- Clock in and out in real-time using EVV mobile devices
- Timesheet is automatically created based on clocking in and out

EVV Claims

Molina will require providers to use HHAeXchange to submit confirmed visits and bill directly to HHAeXchange through the free HHAeXchange Portal.

HHAeXchange Portal:
https://app.hhaexchange.com/hhax/Login.aspx\

Providers must register for HHAX's portal by completing a Provider Portal Questionnaire located at: https://hhaexchange.com/fl-provider-reg

Home Health Services - Billing Tips

- Remember to bill in accordance with HCPCS description
- Units billed must be the total time for the Dates of Service
- Home Health agencies must bill for services on a daily basis. Dates of service may not span over various days.

Doula Services

Doula Services are provided by a professional trained in childbirth who is able to provide emotional, physical, and educational support to a mother who is expecting, is experiencing labor, or has recently given birth. The doula's purpose is to help women have a safe, memorable, and empowering birthing experience

Effective October 1, 2020, Molina Healthcare will cover Doula Services as an Expanded Benefit for Managed Medical Assistance (MMA) and Comprehensive (MMA/LTC) members.

Please review the Doula Benefits Grid and Procedure Codes found at: https://www.molinahealthcare.com/providers/fl/medicaid/comm/training.aspx.

American Therapy Administrators/Health Network One

Therapy Vendor

Molina Healthcare of Florida (Molina) has partnered with American Therapy Administrators of Florida/Health Network One (ATA-FL/HN1) as its new Therapy vendor.

All services other than initial evaluations will require authorization and providers will be required to follow ATA-FL's Prior Authorization process.

To request authorizations:
Authorizations may be requested via fax, phone, or online via the secure Provider Portal.

- **Via Fax** – 1-855-410-0121
- **Via Phone** – 1-888-550-8800
- **Via Portal** at:
  https://asp.healthsystemone.com/pwprequestform/?id=ataflorida

American Therapy Administrators/Health Network One

Therapy Vendor

Claims:

All claims for services rendered after July 1, 2019 claims may be submitted in one of the following formats:

- **Electronic (EDI)** – Change Healthcare (formerly Emdeon)
  - ATA Payer ID: 65062
- **Paper** - CMS 1500 Form -

  American Therapy Administrators of FL/Health Network One
  PO Box 350590
  Fort Lauderdale, FL 33335-0590

- **Provider Portal** – https://asp.healthsystemone.com/pwprequestform/?id=ataflorida

For more information on HN1/ATA-FL, please visit: www.ATAFlorida.com under *Provider Resources*.

Therapy Services Tips

Billing Units

Billing Units:

- Therapies are billed in Units. A unit of service consists of a minimum of 15 minutes of face-to-face therapy treatment between the therapist or therapy assistant and the recipient.

Ex: 1 Hour/Day = 4 -15 Minute Sessions/Day = 4 Units/Day

Providers may submit a claim for payment for a Prior Authorized procedure after the service has been approved and provided.

Radiology Services – Prior Authorization Requirements

- Routine imaging such as X-Rays do not require Prior Authorization*
- Imaging such as CT, MRI, MRA, PET, SPECT require Prior Authorization*
- Diagnostic procedures are covered when the member is inpatient in the hospital

**Please refer to Molina's Prior Authorization Guide and Codification Document for more information.*

***ALL** Elective Services in a Hospital setting will require Prior Authorization.*

Credentialing

The Molina Healthcare Credentialing Department is responsible for performing, tracking and monitoring all aspects of the credentialing and re-credentialing process under the purview of the Quality Management Department for providers joining or participating in the Molina Healthcare network. The credentialing process is designed to meet the State of Florida Requirements and NCQA Standards.

Providers have the right to review their credentials file at any time. The provider must notify the Molina Healthcare Credentialing Department in writing and request an appointed time to review their file and allow up to seven calendar days to coordinate schedules.

MOLINA® HEALTHCARE

Credentialing

Verification

The Credentialing Department will verify provider information that includes, but is not limited to:

- Current, unrestricted license to practice
- Current, valid Drug Enforcement Agency (DEA) certificate
- Education and training
- Work history from the time of medical school graduation
- Board Certification
- Clinical admitting hospital privileges in good standing
- Current, adequate malpractice liability coverage
- All professional liability claims history
- References (if applicable)
- Appropriate (24) hour coverage
- Identify any disciplinary actions and/or sanctions
- Query the National Practitioner Data Bank (NPDB)

MOLINA® HEALTHCARE

Re-Credentialing

Once a provider or facility is approved for participation in Molina Healthcare's network, re-credentialing is performed every three (3) years.

You will receive a re-credentialing application approximately six (6) months before your credentialing period is to expire.

The format used is that of a "profile" and only information that may have changed since the last credentialing will be requested.

Information that is reviewed as part of the re-credentialing process includes but is not limited to:

- Verifying that our providers continue to meet the basic qualifications
- Information from reported quality performance issues, such as utilization data, member satisfaction surveys and customer service reports

MOLINA® HEALTHCARE

Provider Notifications

Providers must immediately notify Molina Healthcare, if any of the following events occur:

- Provider's business license to practice in any state is suspended, surrendered, revoked, terminated, or subject to terms of probation or other restrictions.
- Provider has any malpractice claim asserted against it by a Molina Healthcare member, or any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of provider pursuant to a judgment rendered upon such a claim
- Provider is the subject of any criminal investigation or proceeding
- Provider is convicted for crimes involving moral turpitude or felonies
- Provider is named in any civil claim that may jeopardize Provider's financial soundness
- There is a change in provider's business address, telephone number, ownership, or Tax Identification Number
- Provider's professional or general liability insurance is reduced or canceled
- Provider becomes incapacitated such that the incapacity may interfere with member care for 24 hours
- Any material change or addition to the information submitted as part of provider's application for participation with Molina Healthcare
- Any other act, event or occurrence which materially affects provider's ability to carry out its duties under the Provider Services Agreement

MOLINA® HEALTHCARE

Provider Responsibilities

- Coordinate and supervise the delivery and transition of care to and for each assigned Member.
- Ensure newly enrolled Members receive an initial health assessment no later than one-hundred eighty (180) days following the date of enrollment and assignment to the PCP.
- Ensure 24/7/365 availability for members requiring emergency services.
- Ensure appointment access for all Members in accordance with the Access to Care Standards
- Maintain a ratio of 1 FTE licensed practitioner per 1,500 members, and 1 ARNP or PA for every 750 members above 1,500.
- Provide Child Health Check-Ups (CHCUP) in accordance with the periodicity schedule referenced in the CHCUP section of this handbook.
- Provide immunizations in accordance with the Recommended Childhood Immunization Schedule for the US, or when necessary for the Member's health.
- Participate in the Vaccines for Children Program (VFC) for Members 18 years old and younger.
- Provide immunization information to the Department of Children and Families (DCF) upon request by DCF and receipt of the Member's written permission, for members requesting temporary cash assistance.
- Provide adult preventive care screenings in accordance with the U.S. Preventive Services Task Force guidelines

MOLINA® HEALTHCARE

Provider Responsibilities

- Utilize Molina Healthcare network providers whenever possible. If services necessary are not available in network, contact Utilization Management for assistance.
- Maintain a procedure for contacting non-compliant Members.
- Ensure Members are aware of the availability of non-emergency transportation and assist members with transportation scheduling.
- Ensure Members are aware of the availability of free, oral interpretation and translation services, including Members requiring services for the hearing impaired.
- Provide a physical screening within seventy-two (72) hours, or immediately if required, for children taken into protective custody, emergency shelter, or foster care program by DCF.
- Submit timely, complete and accurate encounters for each visit where the PCP sees the Member.
- Submit encounters on a CMS 1500 form/UB-04 (or electronic equivalent)
- Allow access to Molina Healthcare or its designee to inspect office, records, and/or operations when requested.
- Cooperate in investigations, reviews or audits conducted by Molina Healthcare, AHCA, or any other state or federal agency.

MOLINA® HEALTHCARE

Abuse, Neglect, & Exploitation/ Critical Incidents & Reporting

Providers must immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline toll-free telephone number, **(800) 96ABUSE.** Additionally, all providers, including HCBS providers, must report adverse incidents including events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing, or major medication incidents to Molina Healthcare immediately.

For HCBS providers, Critical Incidents must be reported no more than twenty-four **(24)** hours of the incident. For MMA providers, Adverse Incidents must be reported no more than forty-eight **(48)** hours of the incident.

Documentation related to the suspected abuse, neglect, or exploitation, including the reporting of such, must be kept in a confidential file, separate from the enrollee record. Providers must make the file available to Molina Healthcare or any other State or Federal Agency upon request.

The Critical Incident Form is located on Molina Healthcare's website at: http://www.molinahealthcare.com/providers/fl/PDF/Medicaid/forms_FL_CriticalIncidentReportingForm.pdf

To report a critical incident, provider should email the Critical Incident Form to: MFLQIAlerts@MolinaHealthCare.Com

MOLINA HEALTHCARE

Critical/Adverse Incidents

Reporting Exceptions for MMA

Molina Healthcare does not require Critical Incident reporting from the following providers:

- Health Maintenance Organizations and Health Care Clinics reporting in accordance with s. 641.55, F.S.;
- Ambulatory Surgical Centers and Hospitals reporting in accordance with s. 395.0197, F.S.;
- Assisted Living Facilities reporting in accordance with s. 429.23, F.S.;
- Nursing Facilities reporting in accordance with s. 400.147, F.S.;
- Crisis Stabilization Units, Residential Treatment Centers for children and adolescents, and Residential Treatment Facilities reporting in accordance with s. 394.459, F.S.,

Critical Incidents occurring in these licensed settings shall be reported in accordance with the facility's licensure requirements.

MOLINA® HEALTHCARE

Critical/Adverse Incidents

Reporting Exceptions for LTC

Molina Healthcare does not require Critical Incident reporting from the following HCBS Providers:

- Nursing Facilities reporting in accordance with s. 400.147, F.S.;
- Assisted Living Facilities reporting in accordance with s. 429.23, F.S.

Critical incidents occurring in nursing facilities and ALFs will be addressed in accordance with Florida law.

MOLINA HEALTHCARE

Claims

Claims Submission

Providers may submit claims to Molina Healthcare on paper or electronically, using a current version CMS-1500/UB-04 or the electronic equivalent. Providers may also use our Web Portal to submit claims.

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

Medicare Claims Submission Address
Molina Medicare
P.O. Box 22811
Long Beach, CA 90801

EDI Claims Submission – All LOB's
Emdeon Payor ID# 51062
Emdeon Telephone (877) 469-3263

Web Portal
https://provider.molinahealthcare.com/Provider/Login

MOLINA HEALTHCARE

Claims

Timely Filing

F.S. 641.3155 requires that Participating providers submit all claims within six (6) months of the date of service. Network providers must make every effort to submit claims for payment in a timely manner, and within the statutory requirement.

Corrected Claims may be submitted at any time during the timely filing period of the provider contract.

MOLINA HEALTHCARE

Claims

Electronic Funds Transfer (EFT)

Providers are encouraged to enroll in Electronic Funds Transfer (EFT) in order to receive payments promptly.

Molina Healthcare's EFT provider is Change Healthcare/ProviderNet.

To enroll, visit https://providernet.adminisource.com

To Register for EFT, providers will need the following:

- Last Molina check*
- Name of the Bank Institution
- Bank Routing and Account Number
- Provider NPI
- Provider Tax ID
- Provider Billing Address (pay-to address)
- Voided check

*Providers must have received at least one paper check prior to enrolling for EFT

MOLINA HEALTHCARE

Balance Billing

Participating providers shall accept Molina Healthcare's payments as payment in full for covered services. Providers may not balance bill the Member for any covered benefit, except for applicable copayments, coinsurance, and deductibles, if any.

As a Molina Healthcare of Florida participating provider, your office is responsible for verifying eligibility and obtaining approval for those services that require authorization.

In the event of a denial of payment, providers shall look solely to Molina Healthcare for compensation for services rendered.

MOLINA® HEALTHCARE

Provider Disputes and Appeals

Any disagreement regarding the processing, payment or non-payment of a claim is considered a Provider Dispute. To file a Provider Dispute, providers may contact Customer Service at (855) 322-4076, or send the request for review in writing, along with any supporting documentation to the address below:

Molina Healthcare of Florida
Attn: Provider Disputes
P.O. BOX 527450
Miami, FL 33152-7450
Fax: 877-553-6504

Provider Disputes must be received within one (1) year of the date of payment or denial of the claim. All provider disputes will be reviewed confidentially, and the outcome will be communicated in writing within sixty (60) days or receipt of the Provider Dispute.

Provider Disputes and Appeals

Quick Tips

Disputes (Underpayments, Bundling)

- Claim disputes are typically disputes related to overpayment, underpayments, untimely filing, missing documents (i.e. consent forms, primary carrier explanation of benefits) and bundling issues.
- Overpayment & Underpayments are based on the individual contract and/or Medicaid Fee Schedules
- Disputes can be submitted via phone, fax, provider portal, or by mail.
- Our Molina provider portal is our preferred method of delivery. Its important that all supporting documents are included.
- Disputes impacting more than 10 claims can be submitted via email to: MFLClaimsDisputesProjects@MolinaHealthCare.Com

Appeals (Authorization, Medical Necessity)

- Appeals are those related to denial of authorization.
- Appeals can only be submitted in writing (fax, email, mail) or in-person.
- Our Molina provider portal is our preferred method of delivery. Its important that all supporting documents are included
- Appeals can be submitted via email to: MFL_ProviderAppeals@MolinaHealthCare.Com
- CD Format are always preferred, in order, to reduce large printing and cost of shipping

Maximus

If the Provider Dispute/Appeal results in an unfavorable decision, and the provider has additional documentation supporting their position, the provider may resubmit the Provider Dispute/Appeal for secondary review. In the alternative, providers may also request a review of their original appeal by the State's independent dispute resolution organization, listed below:

Maximus Federal Services State Appeals Process
50 Square Drive Suite 120
Victor, NY 14564
Tel. (866) 763-6395
Fax (585) 425-5296

Quick Facts

- Must be received within (1) year of payment or denial
- Disputes/Appeals shall be resolved within 60 days
- Provider Disputes/Appeals Fax (877)553-6504
- Provider Toll-Free Number (855)322-4076
- New and Corrected Claims* mail to:
  P.O. Box 22812
  Long Beach, CA 90801

*A corrected claim is not a dispute or an appeal.

Provider Disputes and Appeals

Disputes/Appeals Documentation Requirements, including **Claims Projects (10 or more affected claims)***

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

*To avoid delays in processing, all Claims Disputes/Appeals must have supporting documentation (i.e.: Proof of Timely Filing, Explanation of Benefits from Primary Carrier {COB Claims}, Invoices, Medical Notes, Consent Forms, etc.

Fraud, Waste & Abuse

Molina Healthcare of Florida seeks to uphold the highest ethical standards for the provision of health care benefits and services to its members. Federal and state resources dedicated to the prevention and detection of health care fraud have increased substantially in the past few years as part of the effort to control federal program expenditures. Molina Healthcare of Florida is committed to working with federal and state regulatory and law enforcement agencies to help prevent and detect fraud, and to recover funds paid for fraudulent claims.

	State	Federal
Abuse	Means provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care. (409.913 F.S.)	Means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. (42 CFR 455.2)
Fraud	Means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law. (409.913 F.S.)	Means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR 455.2).
Overpayment	Includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake. (409.913 F.S.)	N/A
Waste	Means health care spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity. For example: 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 the Medicaid program	N/A

Examples of Fraud, Waste & Abuse

- Paying or receiving kickbacks for member enrollment or service referrals
- Submitting claims for services not rendered and/or falsifying medical records to increase payment
- Double billing services
- Balance billing members
- Billing services separately that should be billed using a single code (unbundling) or adding modifiers when not appropriate to increase payment
- Use of a medical identification card by someone other than the person identified on the card
- Forgery or alteration of a prescription
- Omitting information or providing misleading or false personal information to obtain health care benefits an individual would not otherwise be entitled to
- Participating in schemes that involve collusion between a provider and a member, such as diverting controlled substance medications for street sales

MOLINA® HEALTHCARE

Reporting Fraud, Waste & Abuse

We offer you the following options to report suspicion of fraud, waste, and abuse or instances of non-compliance. You have the right to report your concerns anonymously and without fear of retaliation.

- You may report suspected cases of fraud and abuse to Molina's AlertLine at: 866-606-3889. https://molinahealthcare.AlertLine.com

To submit written report to Molina Healthcare of Florida via mail or fax:

Compliance Officer
Molina Healthcare of Florida
8300 NW 33rd St, Suite 400
Doral, Florida 33122
Confidential Fax: 866-440-8591

- You may also report directly to the Florida Medicaid Consumer Complaint Hotline at: 888-419-3456.
https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx

MOLINA HEALTHCARE

Translation Services

Molina Healthcare offers oral and written translations services to assist members in communicating with providers, Molina Member Services representatives, and case managers.

These services include:

- Oral and written translation services for members with low English proficiency
- Sign language interpretation services for the hearing impaired
- Member materials in Spanish, Braille, or in audio format.

Providers may request interpreter services for any Molina Healthcare Member, at no cost to the provider or the Member.

If you require translation services for a Molina Member, please contact Member Services at (866)472-4585 or for the hearing impaired, (800)955-8771, to make an appointment with a qualified interpreter.

MOLINA® HEALTHCARE

Cultural Competency

Cultural competency is the readiness and ability of delivering services to all members and valuing the importance of culture diversity.

Molina Healthcare recognizes that every patient encounter is unique. Every patient is different in age, sex, ethnicity, religion or sexual preference and will bring to the medical encounter their unique perspectives and experiences. This factor will always impact communication, compliance and health care outcomes.

Our Cultural Competency Plan describes how the individuals and systems within Molina Healthcare will effectively provide services to people of all cultures, races, ethnic backgrounds 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.

For a full copy of our Cultural Competency Plan, visit our website, www.molinahealthcare.com.

MOLINA® HEALTHCARE

Web Portal Tools

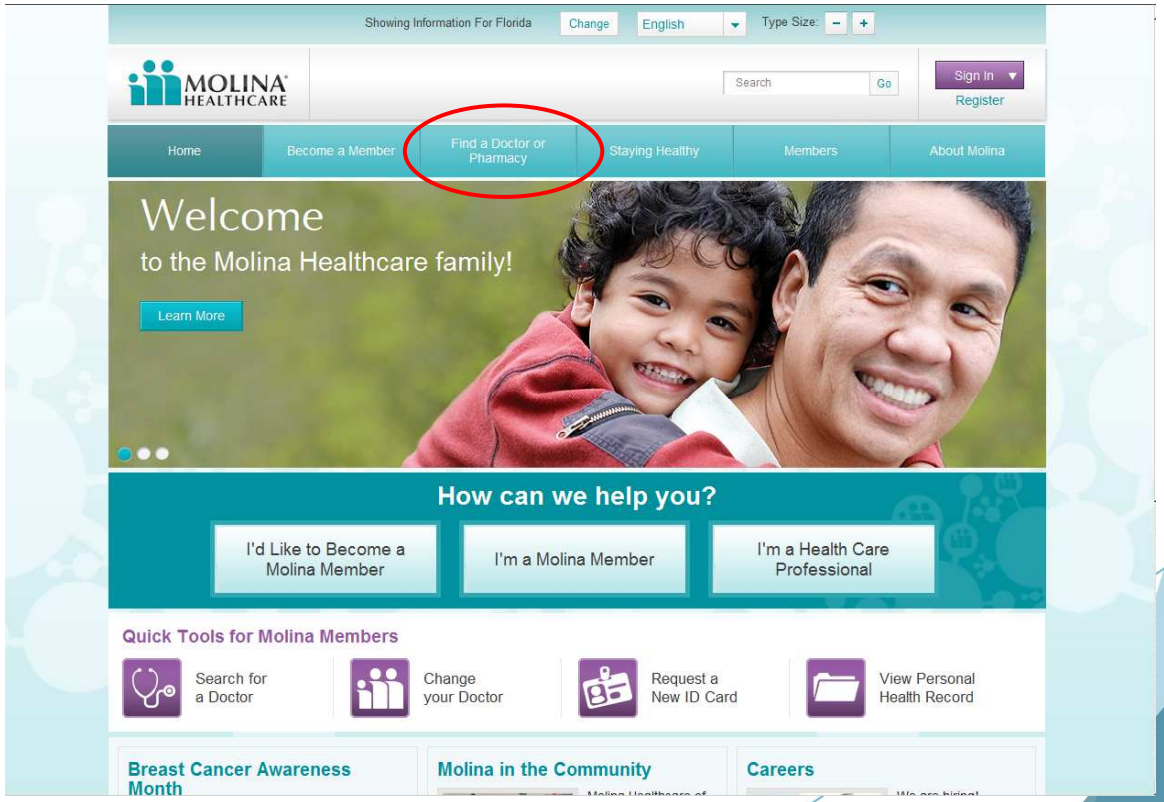
Member Eligibility	Verify effective dates Verify patient demographics Download member roster (PCPs only)
Claims	• Check claim status • Submit claims • Void claims • Correct claims
Authorizations	• Check status of an authorization • Request authorization
HEDIS	• View HEDIS rates by provider & measure • View member details by measure
Claim Disputes	• Submit Claim Disputes
Referrals	•Submit Specialist Referrals (PCP's Only) •Review Referral Status

MOLINA® HEALTHCARE

Provider Directory

Molina Healthcare providers may request a copy of our Provider Directory from their Provider Services Representative, or may use the Online Directory on our website.

To find a provider, visit us at www.molinahealthcare.com, and click Find a Doctor or Pharmacy.



MOLINA HEALTHCARE

Marketplace Evidence Of Coverage (EOC)

Molina Healthcare of Florida's Evidences Of Coverage are written specifically to address the requirements of delivering healthcare services to Molina Healthcare Marketplace members, including your responsibilities as a participating provider. Providers may request printed copies of the respective Metal EOC's, at no cost, by contacting Provider Services at (855) 322-4076, or view them on our website, at:

https://www.molinamarketplace.com/marketplace/fl/en-us/Providers/Provider-Forms.aspx

Provider Handbooks

Molina Healthcare of Florida's Provider Handbooks are written specifically to address the requirements of delivering healthcare services to Molina Healthcare members, including your responsibilities as a participating provider. Providers may request printed copies of the Provider Handbook, at no cost, by contacting Provider Services at (855) 322-4076, or view the handbook on our website, at:

MMA/LTC/SMI Provider Manual
http://www.molinahealthcare.com/providers/fl/PDF/Medicaid/provider-handbook-ltc.pdf

Medicare Provider Manual
http://www.molinahealthcare.com/providers/common/medicare/PDF/provider-manual-fl.pdf

Marketplace Provider Manual
https://www.molinamarketplace.com/marketplace/fl/en-us/Providers/Provider-Forms

MOLINA HEALTHCARE

Networks

Vision

- **Marketplace**
- Vision Service Plan (VSP)
- www.vsp.com
- Telephone: 800-615-1883

- **MMA/LTC**
- iCare Solutions
- www.myicarehealth.com
- Telephone: 855-373-7627

Behavioral Health

- **Beacon Health Options**
- www.beaconhealthoptions.com
- Telephone: 800-221-5487

Laboratory (Preferred)

- **Quest Diagnostics**
- www.questdiagnostics.com
- Telephone: 866-MYQUEST (866-697-8378)

Pharmacy Benefits Manager

- **CVS Caremark**
- www.caremark.com/wps/portal
- Telephone: 800-237-2767

End of Presentation

For a copy of this presentation please email:
MFLProviderNetworkManagement@MolinaHealthcare.com