New Provider Orientation

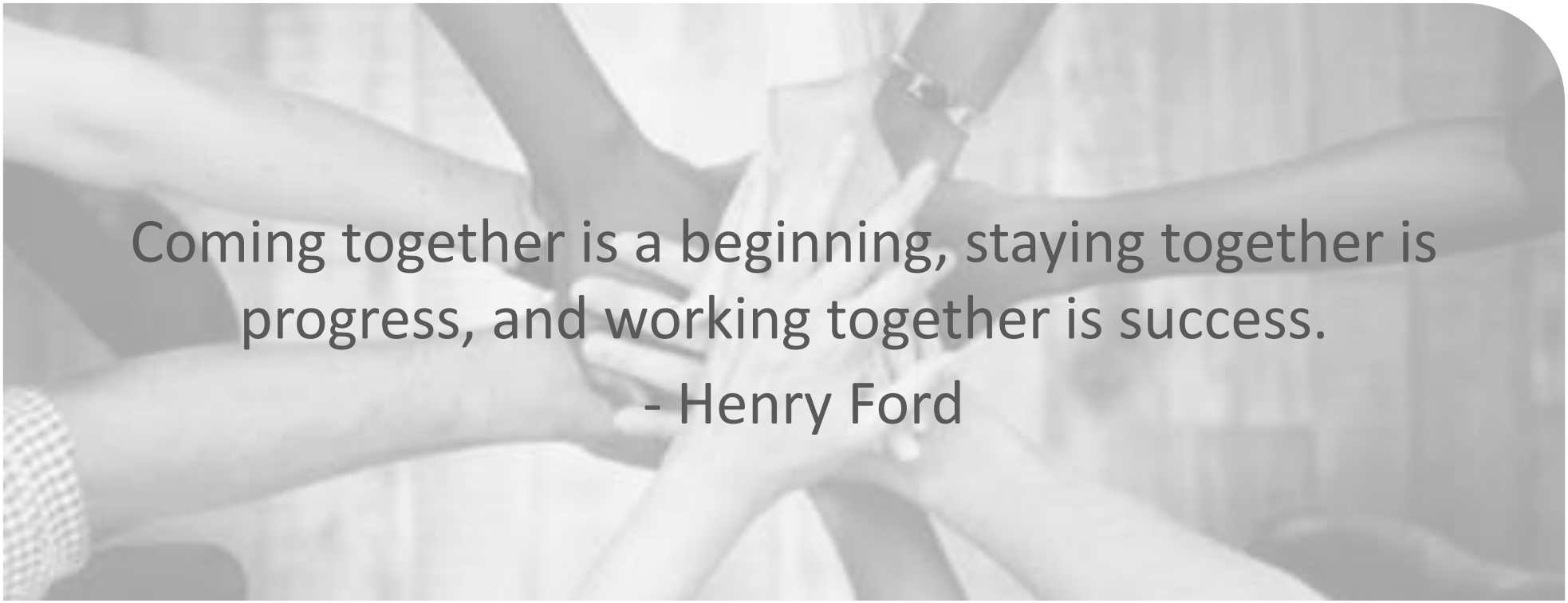
2024

MOLINA® HEALTHCARE

Welcome to Molina Healthcare

MOLINA® HEALTHCARE

Reflection


Coming together is a beginning, staying together is progress, and working together is success.
- Henry Ford

Molina Healthcare values provider relationships

- Molina Healthcare of California (Molina) strongly values our relationship with you and welcomes you to our Molina family and network of providers. As a health plan founded by a physician, Molina shares a common mission with our providers which includes:
  - Ensuring the delivery of high-quality health care services
  - Increasing the delivery of preventive health services and access to care
  - Removing barriers to health care
  - Advocating strongly for the well-being of our members and their families
  - Ensuring health care is available to those who are vulnerable and most in need
  - Providing the right care, in the right setting, at the right time

Required by regulators

Molina Healthcare Provider Relations offers on-going education and training to contracted network/delegates to ensure comprehensive instruction is offered to providers.
Topics include Molina operational processes and requirements to ensure adherence to compliance standards set forth by regulatory bodies: the Centers for Medicare and Medicaid Services (CMS), the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC).

Additional in-services/training will be offered to providers for continuum of education and upon request.

Required by regulators

- Department Healthcare Services (DHCS)
- Department Managed Healthcare (DMHC)

At Molina Healthcare of California, we prioritize the compliance of our network providers with the Medi-Cal Managed Care program.

We ensure that all providers receive comprehensive training to guarantee their full compliance with the contract and all relevant federal and state statutes, regulations, all plan letters and policy letters.

To access the necessary regulatory information, please use the links provided. Your commitment to compliance is vital to our shared success.

Additional in-services/training will be offered to providers for continuum of education and upon request.

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Molina Healthcare - California

Molina Operates in 7 Counties

- Medi-Cal
- Medicare
- Marketplace

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Provider Relations

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Online resources

Information at your fingertips:

As a key partner of Molina, access to the Provider Manuals and other resources are available to you via the Molina website. Molina provides a wide variety of information to answer your questions and assist in ongoing education and compliance with state, federal, and regulatory requirements.

Please feel free to use our online resources where you can access additional information:

- Member Rights and Responsibilities
- Fraud, Waste and Abuse

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Meet us! Provider Relations

Please use this link to secure contact information for our team.

Provider Relations support

- As a contracted provider with Molina, you are an essential part of delivering quality care to our members. We value our partnership and appreciate the family-like relationship that you pass on to our members.

- The role of your Provider Relations Representative (PRR) is to assist your office. Your PRR is available to offer training, conduct visits to provider offices and/or virtual, help with Provider Portal registration, answer questions, and serve as the point of contact for all provider needs.

- Molina welcomes your feedback and looks forward to supporting all your efforts to provide quality care for our members.

Online resources and important contacts

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Online resources

As a key partner of Molina, access to the provider manuals and other resources are available to you via the Molina website. Molina provides a wide variety of information to answer your questions and assist in ongoing education and compliance with state, federal, and regulatory requirements.

Please note, the provider manual is an extension of the provider agreement. Providers and vendors are contractually obligated to comply with requirements and operational procedures addressed in the provider manual.

Name	LOB	Link
Molina website	All	https://www.molinahealthcare.com/members/ca/en-US/pages/home.aspx
Provider manual	Marketplace	https://www.molinamarketplace.com/marketplace/ca/en-us/Providers/~/media/Molina/PublicWebsite/PDF/Providers/ca/Marketplace/2023%20Marketplace%20Provider%20Manual.pdf
	Medicare	https://www.molinahealthcare.com/~/media/Molina/PublicWebsite/PDF/Providers/common/medicare/provider-manual-ca.pdf
	Medi-Cal	https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/ca/MediCal/Medi-Cal-Provider-Manual.pdf

Molina contact information

Radiology authorizations
Phone: (855) 714-2415
Fax: (877) 731-7218

Medi-Cal pharmacy authorizations
Phone: (855) 322-4075
Fax: (866) 508-6445

Medi-Cal Member Services - benefits/eligibility/non-emergent transportation
Phone: (888) 665-4621
Fax: (310) 507-6186
TTY/TDD: 711

Molina Healthcare of California
200 Oceangate, Suite 100
Long Beach, CA 90802
Main Phone (562) 499-6191
Toll Free (888) 665-4621 (TTY : 711)
Business Hours: Monday to Friday
7:30 a.m. - 5:30 p.m.

Provider Contact Center
Phone (855) 322-4075
Fax (562) 951-1529

Fraud and abuse tip line
Phone: (866) 606-3889

Medi-Cal authorizations
Phone: (844) 557-8434
Fax: (800) 811-4804

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Molina contact information Health Net

Health Net member services (Medi-Cal Los Angeles)
Phone: 800-675-6110

Health Net Nurse Advice Line
The Nurse Advice Line is staffed after business hours by registered nurses for Member assistance and referral.
Phone: 800-675-6110

Health Net Website
Health Net's website offers information on member eligibility, claim status, Health Net reference materials such as the Medi-Cal Recommended Drug List, Evidence of Coverage, county-specific Medi-Cal operations manuals, forms, and information on how to contact Health Net with questions.
Provider.healthnet.com

Health Net Community Resource Centers
Get help with insurance questions and enrollment forms. Plus, learn about health classes and many other community resources. East Los Angeles
Phone: 323-415-9120

Medicare Advantage Plans
Health Net Amber, Complete, Green, Gold Select, Healthy Heart, Jade, Ruby, Ruby Select and Sapphire
Phone: 800) 949-3022, option 1
Hearing Impaired (TTY/TDD): 711

For a full list of Health Net contacts, please refer to the Health Net section of the Molina Healthcare provider manual.

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Communications

Provider bulletin

How Molina stays in touch:

- Through Molina Healthcare's Provider Bulletin, the organization stays connected to our contracted providers and allows us to send key updates. Please make sure you provide accurate fax numbers to ensure that important communications from Molina reach you.
- Communications can include but are not limited to: Regulatory changes, business development, member resources and more.
- Submit contact information to your Provider Relations representative. Please provide Molina with your email and/or fax information.
- Molina's Provider Bulletin can be found on our Molina website and through Availity.

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Provider data collection and maintenance

Additions/terms/changes

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Roster submissions: monthly and quarterly

Maintaining an accurate and current provider directory is a state and federal regulatory requirement in accordance with SB 137 and Health and Safety Code Section 1367.27, as well as an NCQA-required element. MHC is required to publish and maintain accurate provider directories monthly.

- Contracted providers are required to submit demographic and data updates, including additions, changes, terminations, and Tax Identification Number (TIN) changes as soon as they become aware of the change.
- Participating healthcare providers must validate their provider director information with MHC every 90 days.
- Include any updated provider office contract and staffing information.
- Submit changes to Molina Healthcare no later than the 15th of every month.

Provider roster submission

- If you are a capitated medical group, IPA, or other group that submits rosters to MHC, please see the detailed instructions listed below. As a reminder, all Medi-Cal providers sent to MHC to be loaded into our network must have completed the Department of Healthcare Services (DHCS) Medi-Cal provider screening and enrollment process.
  - There are two distinct kinds of provider rosters:
    - Monthly provider roster
      - ✓ Including the months when the quarterly roster is sent
      - ✓ The monthly roster has additions, updates, and terms for each month
    - Quarterly provider roster
      - ✓ Every 3 months
      - ✓ Quarterly roster is a full reconciliation file – there will not be any updates from this file
  - Template:
    - Please use the ICE roster template and provide all required 274 data elemer
  - Roster naming convention:
    - GroupName_RosterType_Date.xls
      - ✓ Examples:
        - PIPA_MonthlyRoster_03242023.xls
        - PIPA_QuarterlyRoster_03242023.xls

Provider roster submission (cont'd)

- Delivery method:
  - Send the rosters and provider updates to the appropriate county-shared mailbox
    - Inland Empire: MHCIEProviderServices@MolinaHealthcare.com
    - Los Angeles: MHC_LAProviderServices@Molinahealthcare.com
    - Imperial: MHCImperialProviderServices@Molinahealthcare.com
    - Sacramento: MHCSacramentoProviderServices@Molinahealthcare.com
    - San Diego: MHCSanDiegoProviderServices@Molinahealthcare.com
- Responses regarding roster submission:
  - Any roster, roster update of data maintenance request that does not contain all required data elements will be returned to the contracted provider entity (submitter) to append the missing information.
  - Data required – When the request does not have the required information or data:
    - The request will be sent back to the sender asking for the required data prior to processing the request.
    - Note: The request will not be processed until all required data is received
  - Processing turn around time (TAT) – If all required data is submitted, the requestor will receive an email letting them know the request is being processed and indicating that the TAT for the request will be completed.
  - Roster processing responses – If all required data is received and the roster is processed, we will send additional information. When we send this "process completion" email back to the sender, we will indicate:
    - If any providers have not been processed and the reason why
    - For quarterly rosters (full reconciliation file):
      - ✓ The expectation is that all providers are listed
      - ✓ If providers are not on the "full" quarterly reconciliation roster, we will send these back asking you to send us the terms for these on the next monthly file or explain why they were not on the roster.

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Data maintenance

- Providers are responsible for ensuring that Molina has accurate practice and business information. Accurate information allows us to better support and serve our provider network and members.
  - If you are part of the fee-for-service Molina Direct Network, log into your CAQH account to confirm that the account includes full and accurate information for each provider and/or facility in your practice contracted with Molina.
    - If the information is correct, select the option to confirm.
    - If the information is not correct, update that information in your CAQH account. This must be done within ten (10) business days.
  - If you do not verify your provider directory information each quarter, the law requires that you be removed from Molina's online provider directory until such time as you validate your information. In addition, if you do not validate your information and we cannot reach you, we may also need to remove you from our provider network by terminating your provider agreement.
    - Log into the Availity Portal
      - ✓ Select the Payer Spaces tab
      - ✓ Select Resources
      - ✓ Select CAQH

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Provider directory

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Provider online directory

- Our goal is to ensure members have access to a highly accurate list of available providers through searchable online directories and printed directories.
- The provider online directory (POD) is accessible to Molina members and providers across all lines of business.
- Members and providers can now utilize the user-friendly, intuitive search capabilities of the new POD to find the right health care that they need.
- Select “Find A Doctor” at www.MolinaHealthCare.Com to quickly find a Molina provider or facility today with the new mobile-friendly POD.
- Report changes on the provider directory website via the hyperlink under provider details.

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State Legislation Senate Bill 137 (SB 137)

- SB 137 requires health plans to comply with the following requirements:
  - Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care (DMHC). A willful violation of the act is a crime. Existing law requires a health care service plan to provide a list of contracting providers within a requesting enrollee's or prospective enrollee's general geographic area.
  - Publish and maintain an accurate provider directory with information on contracting providers.
  - Verify provider directory information with contracted providers on a periodic basis.
  - Update the provider online directory weekly and printed directory quarterly.
  - Ensure contracted providers notify the health plan when they are accepting new patients or no longer accepting new patients.
  - Failure to respond to the notification may result in a delay of payment or reimbursement of a claim.

Credentialing

Credentialing

All providers need to be credentialed and entered in the Molina system prior to treating members.

- Providers should utilize the CAQH website for credentialing. https://proview.caqh.org/Login/Index?ReturnUrl=%2fPO%2fProvider%2fProviderDocuments
- Ensure attestation is current and Molina has permission to access application via CAQH. (every 120 days update provider information on CAQH)
- Please address missing document/requested information request within 5 days.
- When adding a new provider to a practice, send provider profile to
  - Inland Empire: MHCIEProviderServices@MolinaHealthcare.com
  - Los Angeles: MHC_LAProviderServices@Molinahealthcare.com
  - Imperial: MHCImperialProviderServices@Molinahealthcare.com
  - Sacramento: MHCSacramentoProviderServices@Molinahealthcare.com
  - San Diego: MHCSanDiegoProviderServices@Molinahealthcare.com
- Credentialing takes 60-90 days to process
- Medi-Cal providers are required to enroll as a Medi-Cal provider through DHCS and PAVE to be in the Plan network Add website resources.

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Timely access requirements

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DHCS access and availability standards

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 OB/GYN (high-volume specialists), hematology/oncologist (high-impact specialists), and behavioral health providers. Providers are required to conform to the access to care appointment standards listed below to ensure that healthcare services are provided in a timely manner. The standards are based on ninety percent 80 percent availability for emergency services and 80 percent or greater for all other services (these goals may vary by plan). The PCP or their designee must be available 24 hours a day, seven days a week to members.

Appointments with the primary care practitioner (PCP)

Members are instructed through their member handbook to call their PCP to schedule appointments for routine/non-urgent care, preventive care, and urgent/emergency care visits. The PCP is expected to ensure timely access to MHC members. If the need for specialty care arises, the PCP is responsible for coordinating all services that fall out of the scope of the PCP's practice.

Appointment access

All providers who oversee the member's health care are responsible for providing the following appointments to Molina members within the noted timeframes. Molina will implement corrective actions for access to healthcare services that do not meet the performance standards.

Interpreter services

Cultural & linguistic resources:

Member resources available in (English | Spanish | Arabic)

Provider resources available in (English)

Language Rights and the Law

- Sections 1557 of the Affordable Care Act (ACA) requires that all limited English proficient (LEP) beneficiaries' language access need be met for all medical appointments.
- To refuse an LEP beneficiary access to language services a violation of that individuals civil rights.
- The ACA also prohibits provider requesting a beneficiary to provider his or her own interpreter or rely on a staff member who is no qualified to communicate directly with the LEP individual.
- Please remember it is never permissible to ask a minor, family member, or friend to interpret.
- Molina complies with all guidance set forth in the ACA, Title VI of the Civil Rights Act, and CA SB 223, which includes instructions for accessing language services in significant member materials.

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Access and availability standards

Access Measures	Access Measures Standards
Timeliness of physician office telephone answer	Within < 45 seconds of the call
Timeliness of physician office response	Within same business day of the call
Appointment Access Type	**Appointment Access Standards**
PCP – Urgent Care not requiring prior authorization	Within < 48 hours of the request
PCP – Urgent Care requiring prior authorization	Within < 96 hours of the request
PCP – Routine/Non-Urgent Care	Within < 10 business days of the request
PCP – Well-Child Preventive Care	Within < 7 business days of the request
PCP – Adult Preventive Care	Within < 20 business days of the request
Non-urgent with a non-physician behavioral health care provider	Within < 10 business days of the request
PCP – Advance Access (same or next business day appointments from the time an appointment is requested)	Not applicable: monitoring purpose only without required standard
PCP – Office Wait Time	Within < 30 minutes from appointment time
Specialist – Urgent Care not requiring prior authorization	Within < 48 hours of the request
Specialist – Urgent Care requiring prior authorization	Within < 96 hours of the request
Specialist – Routine/Non-urgent Care	Within < 15 business days of the request

Access and availability standards

Behavioral Healthcare/Substance Use Disorder Provider Appointment Access Type	BH/SUD Appointment Access Standards
BH – Urgent Care	Within < 48 hours of the request
BH – Urgent Care requiring prior authorization	Within < 96 hours of the request
BH – Routine/Non-Urgent Care	Within < 10 business days of the request
BH – Non-life-threatening emergency	Within < 6 hours of the request
BH –Routine Follow Up	Within ≤ 30 business days from the initial appointment with Prescribers (i.e., Psychiatrist) for a specific condition
BH –Routine Follow Up	Within ≤ 20 business days from the initial appointment with Non-Prescribers (i.e., Psychologist) for a specific condition
After-hour Availability	**After-hour Access Standards**
Appropriate after-hour emergency instruction	If this is a life-threatening emergency, please hang up and dial 911
Timely physician/network provider response to after hour phone calls/pages	Within < 30 minutes
Ancillary Access Type	**Ancillary Access Standards**
Non-urgent appointment for ancillary services	Within < 15 business days

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Availity Provider Portal

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Availity Provider Portal

Availity Essentials is Molina Healthcare's official secure provider portal for traditional (non-atypical) providers. Some of the core features available in Essentials for Molina Healthcare include eligibility & and benefits, attachments, claim status, Smart claims, and Payer Space (submit and check prior authorizations as well as appeal status and appeal/dispute).

If your organization is not yet registered for Availity Essentials and you're responsible for the registration, please register at the Availity Essentials portal:
https://provider.molinahealthcare.com/

For registration issues, call Availity Client Services at (800) AVAILITY (282-4548)
Assistance is available Monday to Friday, 8 a.m. - 8 p.m. ET.

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Availity Essentials Provider Portal

Claims corrections	• Molina providers now have access to a new claim's correction feature from the claim status page. Claims Correction allows you to correct and resubmit a paid or denied claim from the claim status response page
Overpayments	• Eliminate mail and fax for faster dispute resolution and ensure overpayment requests are up to date. View the status and details of any claim Molina has identified as an overpayment. Request additional information, dispute, or resolve the overpayment.
Patient search	• Save time entering patient information for eligibility and benefit inquiries. Enter the patient's member ID or last name, first name, and DOB, and select the patient matching the criteria. The information will automatically populate on the request.
Molina Medicare – Included Molina Healthcare Payor Option	• Select only one option in the payer field. The Molina Medicare option no longer displays in the payer field. When you select the Molina Healthcare option for the region, the plan coverage for the member includes Dual-Eligible, Marketplace, Medicare, and Medicaid.

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Claims and compensation

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Claims – processing standards

Claims submission options:

1. Submit claims directly to Molina Healthcare of California.
2. Claims must be submitted by provider for Medi-Cal and Marketplace to Molina within 90 calendar days after the discharge for inpatient services or the date of service for outpatient services. (unless otherwise stated in your contract) Medicare requires One (1) calendar year after the discharge for inpatient services or the date of service for outpatient services.
3. Clearinghouse (Change Healthcare).
   - Change Healthcare is an outside vendor that is used by Molina Healthcare of California.
   - When submitting fee-for-service EDI Claims (via a clearinghouse) or to Molina Healthcare of California, please utilize the following payer ID 38333.
   - EDI or electronic claims get processed faster than paper claims.
   - Providers can use any clearinghouse of their choosing. Note that fees may apply.

Electronic claims submission:

Register to access our online services with Availity. This will provide you with access to the following:

- Submit professional (CMS1500) and institutional (CMS-1450 [UB04]) claims with attached files.
- Add attachments to previously submitted claims
- Submit corrected claims
- Easily and quickly void claims
- Check claims status
- Receive timely notification of a change in status for a particular claim
- Ability to save incomplete/un-submitted claims
- Create/manage claim templates

If you experience any problems with the Provider Portal, please contact Molina Healthcare's Help Desk at (866) 449-6848 for technical assistance or call your Provider Relations representative directly.

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Claims – quick reference

EDI claims submissions:

- Please call the EDI customer service line at **(866) 409-2935** and/or submit an email to: EDI.Claims@MolinaHealthCare.Com.
- Contact your respective county Provider Relations representative.

Claims Customer Service:

- For assistance with any claims related processes or individual claims issues, please contact Claims Customer Service at **(855) 322-4075**.
- Less than 10 claims.
- Greater than 10 claims, contact your Provider Relations representative.

Timely claim processing:

- Claims processing will be completed for contracted providers in accordance with the timeliness provisions set forth in the provider's contract.
- Unless the provider and Molina or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will process the claim for service within 45 business days after receipt of clean claims.

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Claims – quick reference

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, and provide 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.

Overpayments and incorrect payments refund requests

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

- Providers will receive an overpayment request letter if the overpayment is identified in accordance with state and CMS guidelines. Providers will be given the option to either:
  - Submit a refund to satisfy overpayment,
  - Submit a request to offset future claim payments, or
  - Dispute overpayment findings.

Encounter data

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Encounter data

- Encounter reporting and policy
  - MHC requires all providers/practitioners and delegated entities to submit encounter data reflecting the care and services provided to our members.

    This policy applies to all primary care practitioners (PCPs), contracted either directly with MHC or through an IPA/medical group and delegated entities required to submit encounters. It is important to note the encounter data must also reflect services provided by any ancillary personnel that are under the direction of the PCP, including any physicians (specialists) providing care and services to our patients as defined in their contract with MHC.

    The collection of encounter data is vital to Molina Healthcare of California (MHC). Encounter data provides the plan with information regarding all services provided to our membership.

    Encounter data serves several critical needs. It provides:

    - Information on the utilization of services
    - Information for use in HEDIS studies
    - Information that fulfills state reporting requirements

Encounter data

- HIPAA standards for electronic transactions
  - HIPAA requires the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions. All covered entities must be in compliance with the electronic transactions and code set standards by October 16, 2003.

    Covered entities include:
    - Health plans
    - Health care providers who transmit health information in electronic form, in connection with a transaction covered by HIPAA
    - Health care clearinghouses
- Electronic health care transactions covered under HIPAA that may affect provider organizations are:

Transaction description	HIPAA transaction standard
Claims or encounter information	ASC X12N 837: Professional, or institutional health care claims or encounter ((005010X222A1/005010X223A2/005010X224A2))
Eligibility for a health plan	ASC X12N 270/271: Health care eligibility benefit inquiry and response (005010X279A1
Referral certification and authorization	ASC X12N 278: Health care services request for review and response (005010X217E2)
Claims status	ASC X12N 276/277: Health care claim status request and response ((005010X212E2)
Payment and remittance advice	ASC X12N 835: Health care claim payment/advice (005010X221A1)

Balance billing

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Balance billing

What is balance billing?

- Dual eligible beneficiaries (“Medi-Medi's”) are individuals with both Medicare and Medi-Cal. Medicare health care providers (like doctors and hospitals) cannot bill dual eligible beneficiaries for Medicare cost sharing. This is known as balance billing and is illegal under both federal and state law. Similarly, this protection also applies to Qualified Medicare Beneficiaries (QMBs).

- Billing dual eligible beneficiaries violates Federal law as outlined in section 1902(n)(3)(B) of the Social Security Act, as modified by section 4714 of the Balanced Budget Act of 1997. This section of the Act is available at: http://www.ssa.gov/OP_Home/ssact/title19/1902.htm Protections are also found in California Welfare and Institutions Code section 14019.4.

- For additional information, please visit the following links:
  - Balance-Billing (ca.gov)
  - Balance Billing Fact Sheet_9.13.22 (LAAHU Summit).pdf (ca.gov)
  - OHC and MMCE Fact Sheet
  - What is Fraud? (ca.gov)

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Balance billing

Examples

- Dual eligible beneficiaries or QMBs should never receive a bill for their medical services. Patients should not pay for the following:
- Physician visits and other medical care when they receive from a provider in their provider network.
  - Copays
  - Co-insurance
  - Deductibles
- This applies to both Medicare and Medi-Cal providers.

Exceptions

- Dual eligible beneficiaries may receive a bill for medical services if they have a:
  1. Copay for prescription drugs;
  2. Monthly share of cost for Medi-Cal; and/or
  3. Dental, vision, or hearing aid-related service (or other benefit not covered by Medicare Part A or Part B) that is not covered by their Medicare Advantage plan, and not provided by a Medi-Cal enrolled provider

Provider disputes and resolution process

Provider disputes

- **A Provider Dispute is defined as a written notice prepared by a provider that:**
  - Challenges, appeals, or requests for reconsideration of a claim that has been denied, adjusted, or contested
  - Challenges MHC's request for reimbursement for an overpayment of a claim
  - Seeks resolution of a billing determination or other contractual dispute
- For claims with dates of service in 2004 or after, all provider disputes require the submission of a Provider Dispute Resolution Request Form or a Letter of Explanation, which serves as a written first-level appeal by the provider.
- For paper submissions, MHC will acknowledge the receipt of the dispute within 15 working days and within two working days for electronic submissions.
- If additional information is needed from the provider, MHC has 45 working days to request necessary additional information. Once notified in writing, the provider has 30 working days to submit additional information, or the claim dispute will be closed by MHC.
- **How to Submit Provider Disputes:**
  - **Method 1**: Molina Availity Essentials portal (most preferred method):
    - Log onto the Availity Essentials portal: provider.MolinaHealthcare.com
    - Search and identify adjudicated claims and submit a dispute/appeal
    - Complete the required information on the portal and upload the required documents or proof to support the dispute
  - **Method 2**: Fax to **(562) 499-0633**
  - **Method 3**: **Mail to:** Molina Healthcare of California
    Attn: Provider Dispute Resolution Unit
    P.O. Box 22722
    Long Beach, CA 90801

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Utilization management

Utilization management

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 the 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 and CM processes.
- Ensuring UM decision-making tools are appropriately applied in determining medical necessity decision.

Utilization management

Medical necessity

“Medically necessary” or “medical necessity” is defined under Title 22, California Code of Regulations, Section 51303(a) as “health care services …which are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury...” In any of those circumstances, if a patient’s condition produces debilitating symptoms or side effects, then it is also considered medically necessary to treat those.

Molina has partnered with Milliman Care Guidelines (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**.** To learn more about MCG or cite for guideline transparency, visit MCG's website or call (888) 464-4746.

Utilization management

UM Decisions

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

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

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.

Providers can contact Molina's Healthcare Services department at: (844) 557-8434 to obtain Molina's UM criteria.

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

Utilization management

Peer to peer

Upon receipt of an adverse determination, the provider (peer) may request a peer-to-peer discussion within five business days of the decision. When at all possible, the Molina medical director who made the initial denial decision will be available to discuss the case with the provider.

A “peer” is a physician, physician assistant, or nurse practitioner who provides care directly to the member. Contracted external parties, administrators, or facility UM staff can request that peer-to-peer telephone communication be arranged and performed. However, in general, they are not the typical “peer” with whom Molina’s medical director discusses a case.

How to request a peer-to-peer (P2P): Call 866-814-2221 (Monday to Friday, 8 a.m. – 5 p.m.)

When requesting a peer-to-peer, please include the following:

- Member name and ID#
- Auth ID# number
- Dates of Service for P2P
- Facility name
- Requesting provider name, contact number, and best time to call

Key functions of the UM program

Eligibility and oversight

- Eligibility verification
- Benefit administration and interpretation
- Verification that authorized care correlates to member's medical necessity need(s) and benefit plan
- Verifying of current physician/hospital contract status

Resource management

- Prior authorization and referral management
- Pre-admission, admission and inpatient review
- Referrals for discharge planning and care transitions
- Staff education on consistent application of UM functions

Quality management

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

Utilization management

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 member's care

For more information about Molina's UM program, or to obtain a copy of the Health Care Services (HCS) program description, clinical criteria used for decision making, and how to contact a UM reviewer, access the Molina website or contact the Molina's Services department at (844) 557-8434.

MOLINA® HEALTHCARE

Prior authorization and utilization management

Covered & carved out services

MOLINA® HEALTHCARE

Prior authorization code guide

Clinical guidelines/based on practice guidelines are used for PA

- Molina requires a prior authorization for specified services as long as the requirement complies with federal or state regulations and the Molina hospital or Provider Relations agreement.
- The Molina prior authorization matrix of codes that require prior auth is customarily updated quarterly, but may be updated more frequently as appropriate, and is posted on the Molina website at: https://www.molinahealthcare.com/providers/ca/medicaid/forms/fuf.aspx
- 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 Code Matrix, Prior Authorization Guide

PA code guide is updated annually and is subject to change as needed

MOLINA® HEALTHCARE

Requesting prior authorization

Availity Essentials Portal:

- Participating providers are encouraged to use the Molina Availity Essentials Portal for prior authorization submissions whenever possible.
- The benefits of submitting your prior authorization request through the Availity Essentials Portal are:
  - Create and submit prior authorization requests
  - Check status of authorization requests
  - Receive notification of change in status of authorization requests
  - Attach medical documentation required for timely medical review and decision making

Fax:

- The prior authorization request form can be faxed to Molina at: (800) 811-4804.

Phone:

- Prior authorizations can be initiated by contacting Molina's Health Care Services department at: (844) 557-8434.
- It may be necessary to submit additional documentation before the authorization can be processed.

MOLINA® HEALTHCARE

Carved out services

- The pharmacy benefit has been carved out to Medi-calRx.
- Dental screening is carved out to Denti-Cal.
- Substance use disorder (SUD) treatment is carved out to the county.

For more information on the Medi-Cal Rx program and portal go to, https://medicalrx.dhcs.ca.gov/

Please refer to the Molina Provider Manual for additional information.

MOLINA® HEALTHCARE

Authorization contacts

Service area	Phone	Fax	Service Area	Phone	Fax
Prior authorization	(844) 557-8434	(800) 811-4804	Pharmacy authorizations	(855) 322-4075	(866) 508-6445
Member service benefits/eligibility	(888) 858-2150		Provider Contact Center	(888) 858-2150	(562) 499-0619
Behavioral health	(844) 557-8434	(800) 811-4804	Dental	(877) 433-6825	(949)830-1655
Radiology authorizations	(855) 714-2415	(877) 731-7218	Transportation	(855) 322-4075	
Transplant authorizations	(855) 714-2415	(877) 813-1206	Vision	(800) 877-7195 (VSP) www.vsp.com/advantage	

Nurse Advice Line (24 hours a day, 7 days a week): (888) 275-8750 (TTY: 711)

- Members who speak Spanish can press 1 at the IVR prompt; the nurse will arrange for an interpreter, as needed, for non-English/Spanish speaking
- No referral or prior authorization is needed.

Providers may utilize Molina Healthcare's website at:

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

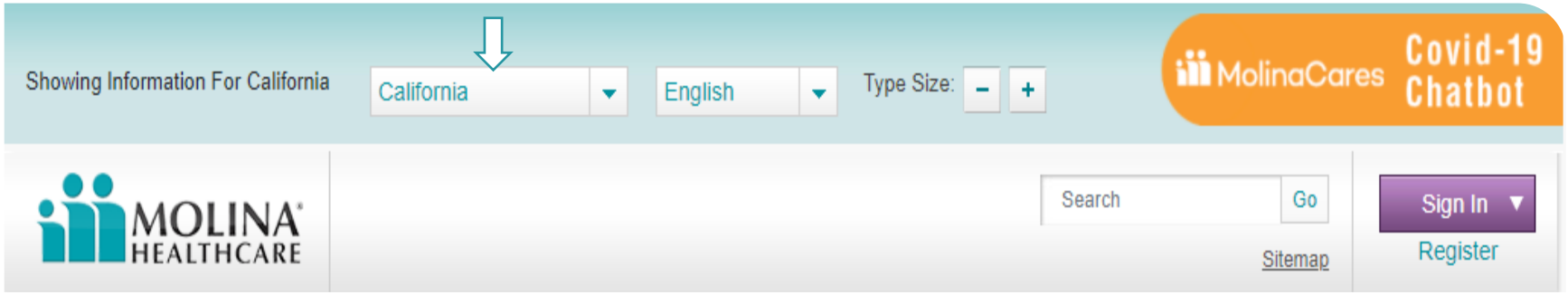
- Available features include:
  - Authorization submission and status
  - Download frequently used forms
  - Provider directory
  - Nurse Advice Line report
  - Claims submission and member eligibility status

MOLINA® HEALTHCARE

Prior Authorization Lookup Tool

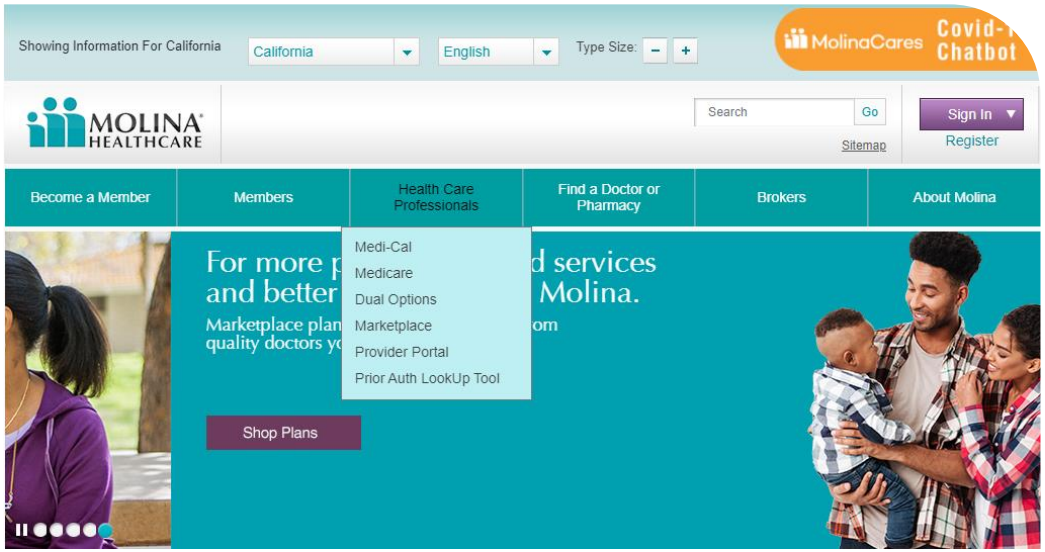
Provider access

- Providers will start at: www.molinahealthcare.com
- Choose your state from the drop down



Hover over **"Health Care Professionals"** and select **"Prior Auth Look Up Tool"** from the drop-down menu for quick access to the tool.

Choose your line of business (LOB)



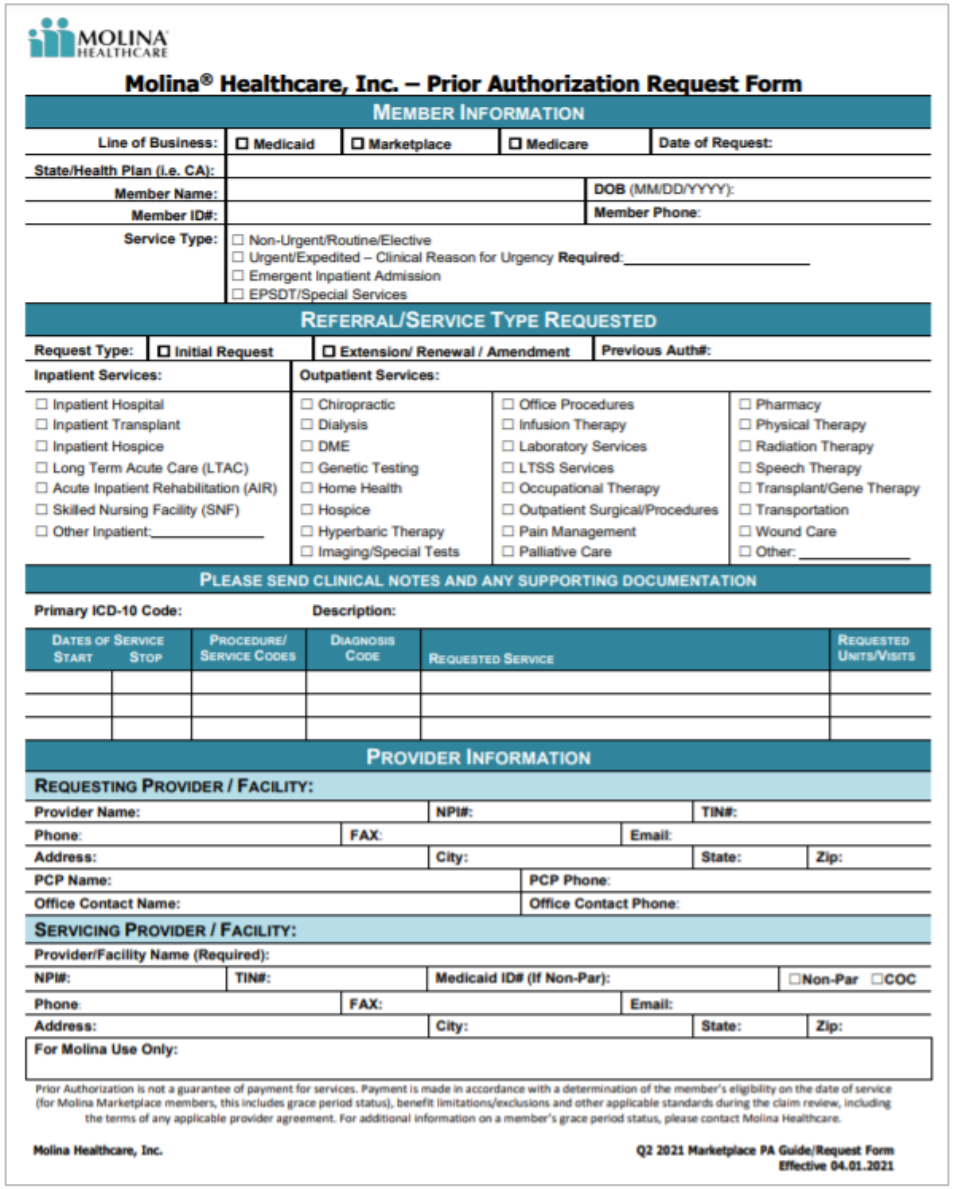
Need a Prior Authorization?

Code LookUp Tool

MOLINA HEALTHCARE

Prior authorization forms

Standard request form



MOLINA HEALTHCARE

Molina® Healthcare, Inc. – Prior Authorization Request Form

MEMBER INFORMATION

Line of Business:	☐ Medicaid	☐ Marketplace	☐ Medicare	Date of Request:
State/Health Plan (i.e. CA):				
Member Name:			DOB (MM/DD/YYYY):	
Member ID#:			Member Phone:	

Service Type:
☐ Non-Urgent/Routine/Elective
☐ Urgent/Expedited – Clinical Reason for Urgency **Required**:_____
☐ Emergent Inpatient Admission
☐ EPSDT/Special Services

REFERRAL/SERVICE TYPE REQUESTED

Request Type: ☐ Initial Request ☐ Extension/ Renewal / Amendment Previous Auth#:

Inpatient Services:	Outpatient Services:		
☐ Inpatient Hospital	☐ Chiropractic	☐ Office Procedures	☐ Pharmacy
☐ Inpatient Transplant	☐ Dialysis	☐ Infusion Therapy	☐ Physical Therapy
☐ Inpatient Hospice	☐ DME	☐ Laboratory Services	☐ Radiation Therapy
☐ Long Term Acute Care (LTAC)	☐ Genetic Testing	☐ LTSS Services	☐ Speech Therapy
☐ Acute Inpatient Rehabilitation (AIR)	☐ Home Health	☐ Occupational Therapy	☐ Transplant/Gene Therapy
☐ Skilled Nursing Facility (SNF)	☐ Hospice	☐ Outpatient Surgical/Procedures	☐ Transportation
☐ Other Inpatient:_____	☐ Hyperbaric Therapy	☐ Pain Management	☐ Wound Care
	☐ Imaging/Special Tests	☐ Palliative Care	☐ Other:_____

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code: Description:

Dates of Service Start	Dates of Service Stop	Procedure/ Service Codes	Diagnosis Code	Requested Service	Requested Units/Visits

PROVIDER INFORMATION

REQUESTING PROVIDER / FACILITY:

Provider Name:		NPI#:		TIN#:
Phone:	FAX:		Email:	
Address:		City:	State:	Zip:
PCP Name:		PCP Phone:		
Office Contact Name:		Office Contact Phone:		

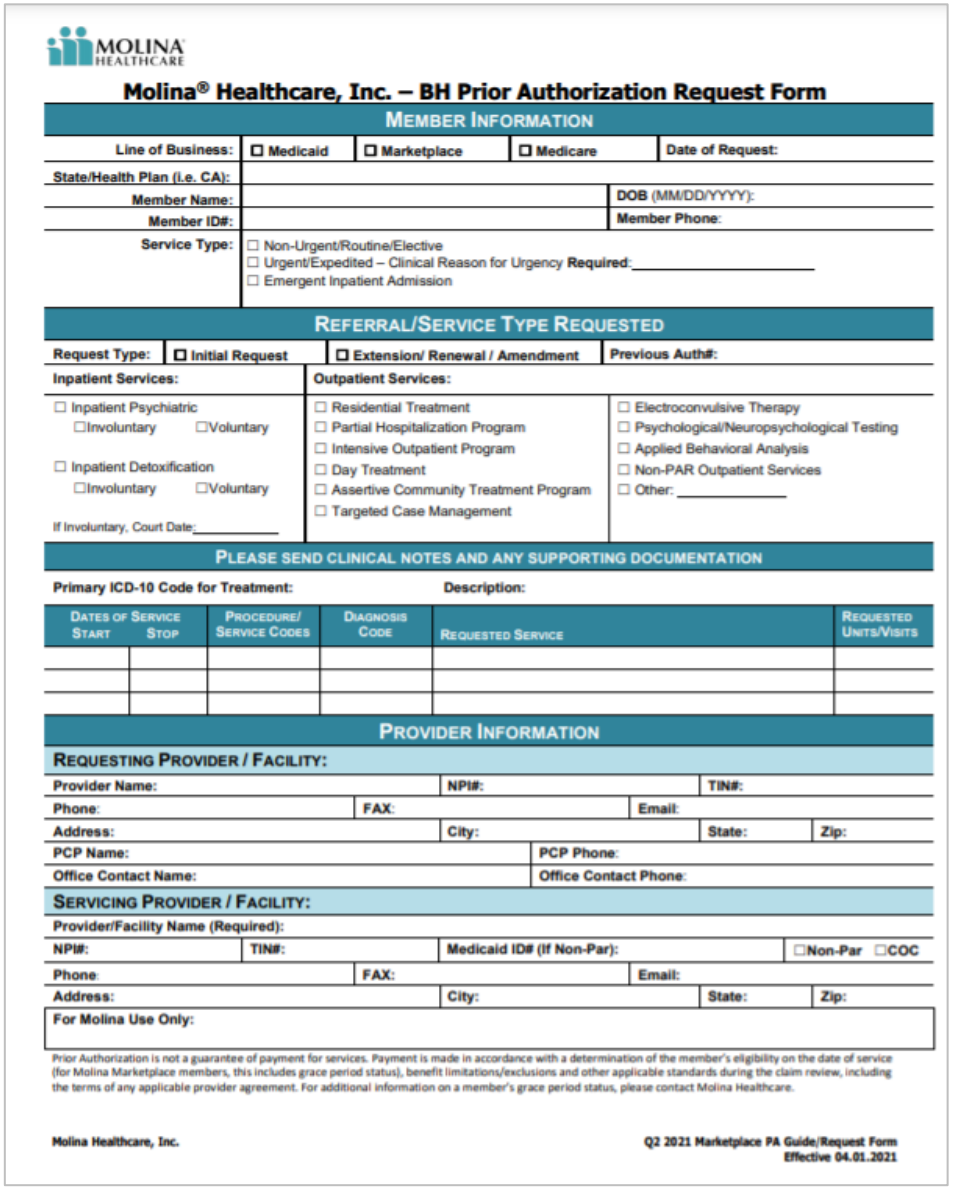
SERVICING PROVIDER / FACILITY:

Provider/Facility Name (Required):				
NPI#:	TIN#:	Medicaid ID# (If Non-Par):	☐Non-Par	☐COC
Phone:	FAX:	Email:		
Address:	City:	State:	Zip:	
For Molina Use Only:				

Prior Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility on the date of service (for Molina Marketplace members, this includes grace period status), benefit limitations/exclusions and other applicable standards during the claim review, including the terms of any applicable provider agreement. For additional information on a member's grace period status, please contact Molina Healthcare.

Molina Healthcare, Inc. Q2 2021 Marketplace PA Guide/Request Form Effective 04.01.2021

Behavioral health request form



MOLINA HEALTHCARE

Molina® Healthcare, Inc. – BH Prior Authorization Request Form

MEMBER INFORMATION

Line of Business:	☐ Medicaid	☐ Marketplace	☐ Medicare	Date of Request:
State/Health Plan (i.e. CA):				
Member Name:			DOB (MM/DD/YYYY):	
Member ID#:			Member Phone:	

Service Type:
☐ Non-Urgent/Routine/Elective
☐ Urgent/Expedited – Clinical Reason for Urgency **Required**:_____
☐ Emergent Inpatient Admission

REFERRAL/SERVICE TYPE REQUESTED

Request Type: ☐ Initial Request ☐ Extension/ Renewal / Amendment Previous Auth#:

Inpatient Services:	Outpatient Services:	
☐ Inpatient Psychiatric	☐ Residential Treatment	☐ Electroconvulsive Therapy
☐Involuntary ☐Voluntary	☐ Partial Hospitalization Program	☐ Psychological/Neuropsychological Testing
☐ Inpatient Detoxification	☐ Intensive Outpatient Program	☐ Applied Behavioral Analysis
☐Involuntary ☐Voluntary	☐ Day Treatment	☐ Non-PAR Outpatient Services
	☐ Assertive Community Treatment Program	☐ Other:_____
If Involuntary, Court Date:_____	☐ Targeted Case Management	

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code for Treatment: Description:

Dates of Service Start	Dates of Service Stop	Procedure/ Service Codes	Diagnosis Code	Requested Service	Requested Units/Visits

PROVIDER INFORMATION

REQUESTING PROVIDER / FACILITY:

Provider Name:		NPI#:		TIN#:
Phone:	FAX:		Email:	
Address:		City:	State:	Zip:
PCP Name:		PCP Phone:		
Office Contact Name:		Office Contact Phone:		

SERVICING PROVIDER / FACILITY:

Provider/Facility Name (Required):				
NPI#:	TIN#:	Medicaid ID# (If Non-Par):	☐Non-Par	☐COC
Phone:	FAX:	Email:		
Address:	City:	State:	Zip:	
For Molina Use Only:				

Prior Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility on the date of service (for Molina Marketplace members, this includes grace period status), benefit limitations/exclusions and other applicable standards during the claim review, including the terms of any applicable provider agreement. For additional information on a member's grace period status, please contact Molina Healthcare.

Molina Healthcare, Inc. Q2 2021 Marketplace PA Guide/Request Form Effective 04.01.2021

MOLINA HEALTHCARE

Case management and Long-Term Services and Support (LTSS)

Care management

- Assists members of all ages with complex needs and/or who have difficulty coordinating their care due to:
  - Multiple comorbid diagnoses & medications
  - Needing help in accessing care or Continuity of Care
  - Experiencing health and/or behavioral health crisis
  - High utilization (admissions, ED visits)
  - Barriers in accessing care
  - Non-adherence
  - Risk for Long-term care/institutionalization
  - Long Term Services and Supports (LTSS)
  - Collaboration with the Interdisciplinary Care team including the PCP

- Basic case management:
  - Provided by PCP in collaboration with Molina
  - Initial health assessment (IHA)
  - Coordination of necessary health care services

Member identification sources: member self-referral, PCP, MG, reports, internal departments, etc.

MOLINA® HEALTHCARE

Case management

Molina provides multiple avenues for members to be referred to the plan for case management services beyond what the PCP provides, including telephone, fax, or email.

To refer a member for complex case management:

Phone: (833) 234-1258
Fax: (562) 499-6105
Email: MHCCaseManagement@MolinaHealthcare.com
For members under 21: MHCHealthcareServicesCCS@MolinaHealthCare.com

Molina welcomes referrals from PCPs, hospital discharge planners, social workers, CCS case managers, Early Start staff, members and/or member's family/caregivers, specialty physicians, and other practitioners. CM Program and contact information is also available from Member Services, the 24-hour Nurse Advice Line, and in the Health Care Professionals sections on the Molina website.

Members appropriate for complex case management are those who have complex service needs and may include your patients with multiple medical conditions, high levels of dependence, conditions that require care from multiple specialties, and/or additional social, psychosocial, psychological, and emotional issues that exacerbate the condition, treatment regime and/or discharge plan.

Care management programs

- Case management
- Transition of Care Program (ToC)
- Major Organ Transplant (MOT)
- My Care – palliative care program
- Community Supports

Transitions of Care (TOC)

- Coaches assist members when they are admitted to the hospital and through their transitions to other levels of care.
- Identification includes the Molina inpatient census and admission, discharge, and transfer (ADT) feed from health information exchanges.
- Areas they assist with:
  - Following discharge orders from the hospital:
    - Closing the loop on requested services (e.g., home health, DME).
    - Medication review.
- Education of signs and symptoms and when to report worsening conditions.
- Assist and ensure timely follow-up appointment(s) after hospitalization:
  - Goal is to secure appointments within 7 days of discharge or sooner if needed to reduce avoidable hospitalizations.
- Referrals to resources to help reduce barriers related to SDOH (e.g., transitional meals, transportation, ECM/community supports).
- Assess and refer to complex case management for ongoing needs.

Major Organ Transplant (MOT)

- Dedicated case managers provide care management services for all members undergoing evaluation for MOT, all members listed for any transplant (including kidney), and one year of follow-up.
- All transplant care must be provided through a DHCS-approved Center of Excellence (COE).
- Providers requesting transplant evaluation authorization for members enrolled in an IPA, also need to submit authorization to Molina for the facility component and listing.
- Since Molina is responsible for the transplant surgery and the bulk of transplant costs for members enrolled in an IPA, please provide MOT evaluation authorization to Molina's preferred COEs only.
- If Molina receives requests for non-preferred COEs approved by the IPA, Molina will redirect to contracted COEs.

MOLINA® HEALTHCARE

Major Organ Transplant (MOT)

Molina Preferred Centers of Excellence

Sacramento County

UC Davis

- Bone Marrow
- Kidney

UCSF

- Bone Marrow (Only if UC Davis has declined the referral)
- Heart
- Kidney-Pancreas
- Liver
- Lung

California Pacific Medical Center

- Bone Marrow (Only if UC Davis has declined the referral)
- Kidney-Pancreas
- Liver

Sutter Memorial Sacramento

- Bone Marrow (Only if UC David has declined the referral)
- Heart

MOLINA® HEALTHCARE

Major Organ Transplant (MOT)

Molina Preferred Centers of Excellence

Los Angeles County

Cedars Sinai Medical Center
- Bone marrow
- Heart
- Liver
- Lung

City of Hope
- Bone marrow

Riverside/San Bernardino County

Loma Linda University Medical Center
- Bone marrow
- Heart
- Kidney-Pancreas
- Liver
- Lung

San Diego County

Scripps Green Hospital
- Liver

University of California San Diego
- Bone marrow
- Heart
- Liver
- Lung

Scripps Hospital La Jolla
- Bone marrow

Sharp Memorial Hospital

MOLINA® HEALTHCARE

My Care – palliative care program

- All ages, primarily home-based palliative care only for Medi-Cal members
  - A specialized medical care for patients living with a serious illness.
  - The goal is to improve the quality of life for both the patient and the family.
- Criteria for all diagnoses:
  - Advanced Illness.
  - Started to use ER and inpatient hospital services related to their disease.
  - Member's death within a year would not be unexpected.

MOLINA HEALTHCARE

My Care – palliative care program

Benefits of enrollment:

- Home visits with medical team (MD, NP, nurse, MSW, chaplain): Minimum of 4 outreaches/month. At least 1 is face-to-face.
- Advanced care planning.
- Vendor's 24/7 Nurse Advice line.
- Care coordination with the treating physician and Molina (facilitate authorizations for DME, outpatient paracentesis, etc.).
- Symptoms management (pain, difficulty breathing, nausea, etc.).
- Reduce unnecessary admissions and help the member obtain the right level of care at the right time and place.
- Monthly operational meetings with vendors to review all referrals and enrolled members.

If a Molina member is identified as needing My Care services:

- Submit a referral to the palliative care vendor or
- Notify the PCP/specialist who will complete the service request form (prior auth form).
- Once approved, the palliative care vendor will reach out to the member to enroll.
- Send referrals directly to Molina preferred providers:
  - Lightbridge Hospice (San Diego County)
  - Elizabeth Hospice (San Diego County)
  - Snowline (Sacramento County)
  - ProHealth (Sacramento County)
  - Silverado (Los Angeles, Riverside and San Bernardino Counties)
  - Roze Room Hospice (Los Angeles County)

Long Term Services and Support (LTSS)

- Molina Medi-Cal members have access to a variety of Long-Term Services and Supports (LTSS) to help them meet their daily needs for assistance and improve their quality of life. LTSS benefits are provided over an extended period, mainly in member homes and communities, but also in facility-based settings such as nursing facilities as specified in his/her Individualized Care Plan. Overall, Molina's care team model promotes improved utilization of home and community-based services to avoid hospitalization and nursing facility care.
  - LTSS includes all the following:
  - Community-Based Adult Services (CBAS)
  - In-Home Supportive Services (IHSS)
  - Multipurpose Senior Services Program (MSSP)
  - Long Term Care, Custodial Level of Care in a nursing or Subacute facility
  - Intermediate Care Facility for the Developmentally Disabled (ICF/DD)

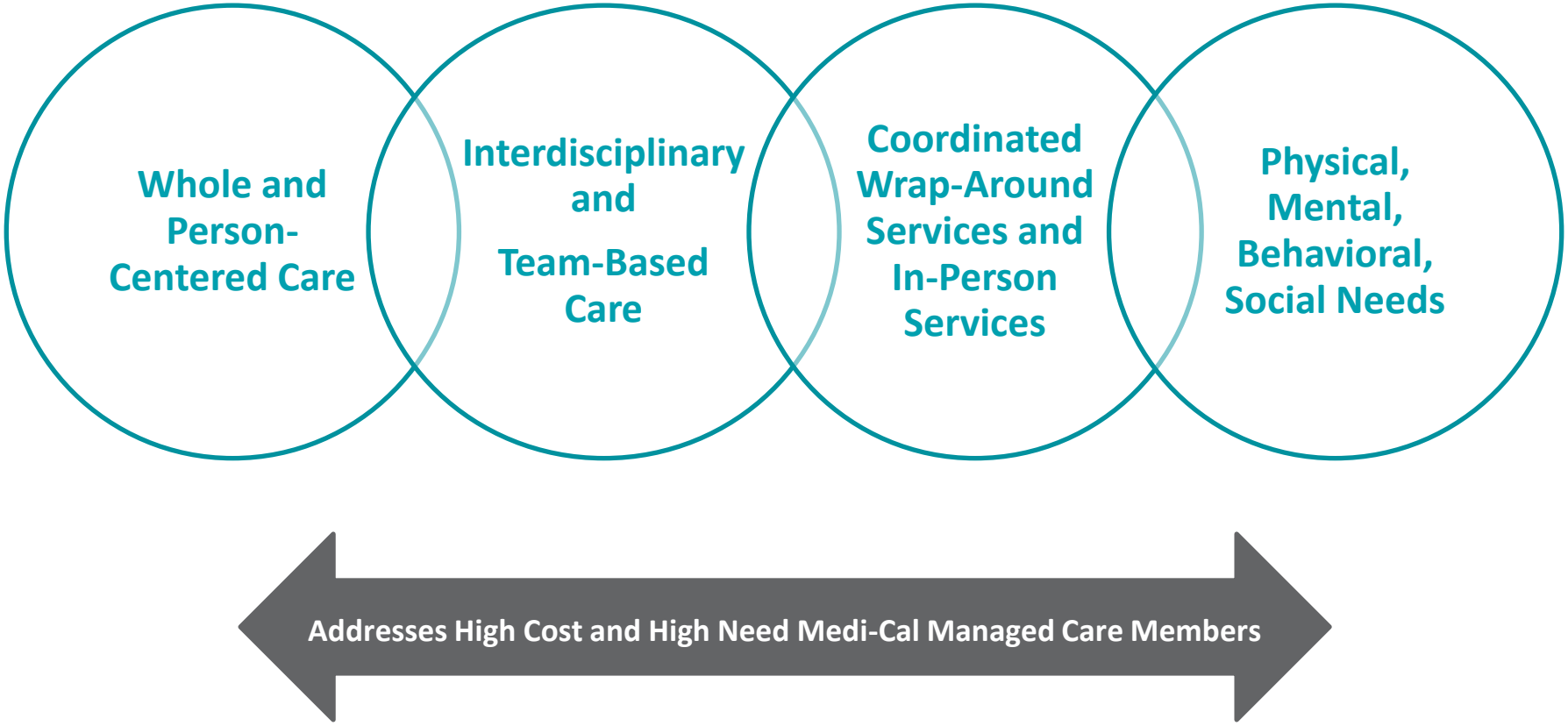
To access information about how to identify LTSS needs, eligibility criteria, and how to appropriately refer for LTSS services, please refer to HEALTHCARE SERVICES: LONG-TERM SERVICES AND SUPPORTS in the Molina Healthcare Provider Manual.

Enhanced Care Management (ECM) and Community Supports (CS)

MOLINA® HEALTHCARE

Enhanced Care Management Framework

ECM is a statewide whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Members with the most complex medical and social needs.



MOLINA® HEALTHCARE

ECM population of focus | Timeline

ECM Populations of Focus	Go-Live Date
Adults and their Families Experiencing Homelessness	1/1/2022
Adults without Dependent Children/Youth Living with Them Experiencing Homelessness	7/1/2023
Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness	7/1/2023
Adults at Risk for Avoidable Hospital or ED Utilization	1/1/2022
Children/Youth at Risk for Avoidable Hospital or ED Utilization	7/1/2023
Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs	1/1/2022
Children/Youth with Serious Mental Health and/or Substance Use Disorder (SUD)	7/1/2023
Adults Transitioning from Incarceration within the past 12 months	1/1/2024
Children/Youth Transitioning from Youth Correctional Facility within the past 12 months	1/1/2024
Adults Living in the Community who are at Risk for LTC Institutionalization	1/1/2022
Adult Nursing Facility Residents transitioning to the Community	1/1/2022
Children/Youth Enrolled in CCS or CCS WCM with Additional Needs beyond the CCS Condition	7/1/2023
Children/Youth Involved in Child Welfare	7/1/2023
Adults with Intellectual or Developmental Disabilities (I/DD) **Must meet another Population of Focus in order to meet this one*	1/1/2022
Children/Youth with Intellectual or Developmental Disabilities (I/DD) **Must meet another Population of Focus in order to meet this one)*	7/1/2023
Adults Pregnant and Postpartum Individuals At Risk for Adverse Perinatal Outcomes **Must meet another Population of Focus in order to meet this one*	1/1/2022
Children/Youth Pregnant and Postpartum Individuals At Risk for Adverse Perinatal Outcomes **Must meet another Population of Focus in order to meet this one)*	7/1/2023
Adults and Child/Youth Birth Equity	1/1/2024

MOLINA® HEALTHCARE

ECM process member referrals

The ECM Team will receive ECM member referrals from external providers, internal (Molina CM & TOC), and member self-referrals (from the Call Center) via email through the Molina ECM Team Inbox.

The ECM Team will review the referral to ensure the member qualifies for the program, process the referral by completing an ECM Enrollment Assessment, assigning an ECM Provider, and informing the ECM Provider of the newly assigned member.

ECM Provider has 90 days to complete an HRA and Care Plan

- ECM Provider assigns an ECM LCM
- Assist with care coordination services
- Updates care plan
- Educates/coach member
- Facilitates referrals to CS (as needed)
- Continually reassessing to determine if member should continue with ECM or need to be downgraded to lower level of care (like Molina CM) or discharged/graduated completely from the ECM program.

MOLINA® HEALTHCARE

Community Supports eligibility criteria and reminders

- Completed referrals must be submitted to prior authorization team for review.
- CS services require authorization (except Sobering Centers)
  - Each CS has specific qualifying criteria for members to be approved for the service based on DHCS Policy Guide. The criteria is listed on the referral form for each CS service.
  - The request will be reviewed and decided by the prior authorization team.
- Duplication of services is not permitted
  - Members cannot be receiving these services through another avenue, such as a state or county-funded program.
- Reminders:
  - Check monthly for health plan enrollment & eligibility
  - Housing CS:
    - Housing deposit requests that include items not on the pre-approved list must be discussed.
  - Notify Molina for all discontinuation requests via email as soon as possible.
    - Outreach in advance to the community support team at MHC_CS@molinahealthcare.com for any questions about specific CS services.

Purpose and Administration of Community Supports

Medi-Cal managed care plans will have the option to integrate Community Supports into their population health management plans – often in combination with the new enhanced care management benefit

Community Supports would be focused on addressing combined medical and social determinants of health needs and avoiding higher levels of care or other future health care costs

Community Supports must be cost effective. For example, Community Supports might be provided as a substitute for, or to avoid, hospital or nursing facility admissions, discharge delays and emergency department use

MOLINA® HEALTHCARE

Molina's Community Supports

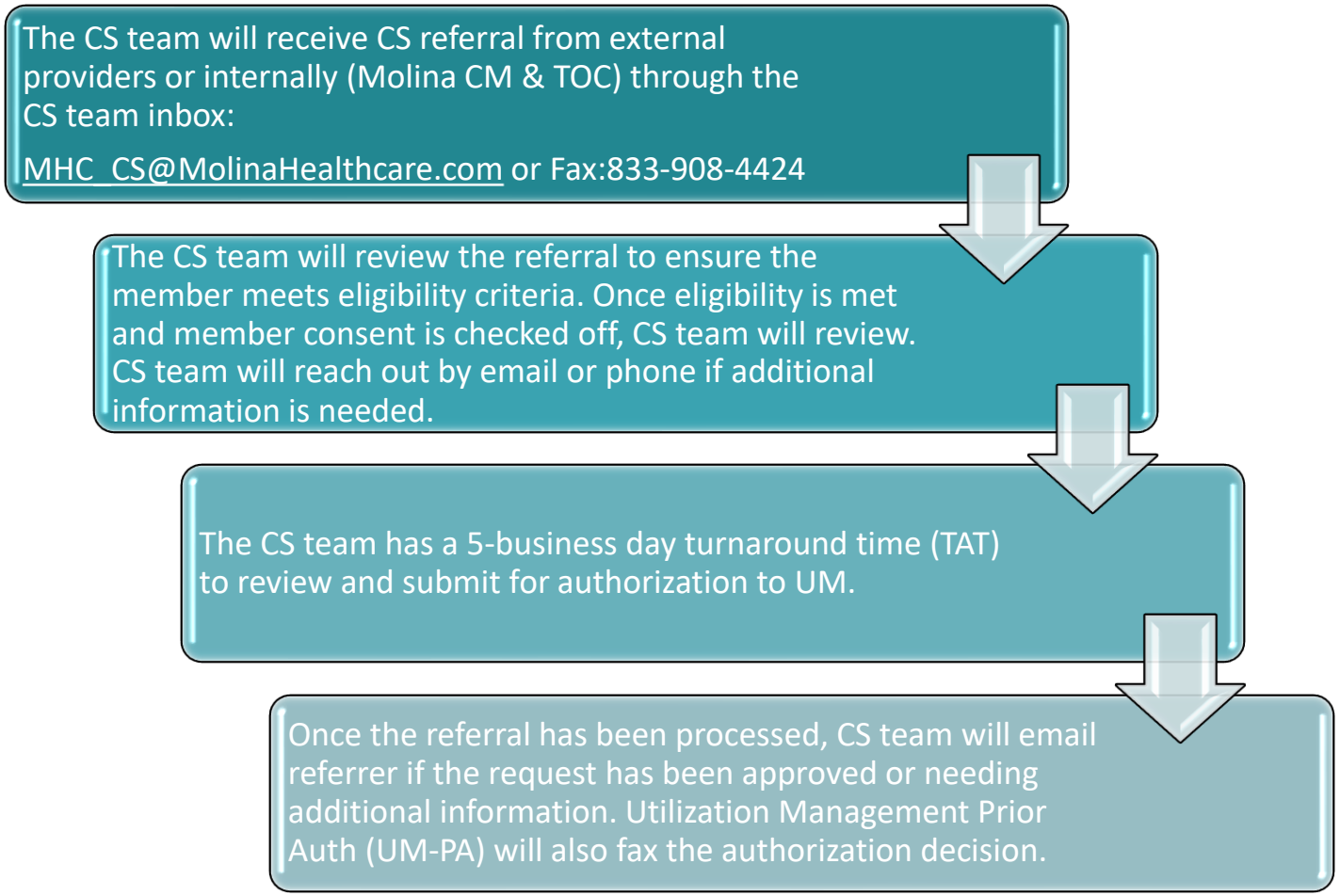
Community Supports	Los Angeles (HN)	Riverside	Sacramento	San Bernardino	San Diego
Housing Transition Navigation Services	X	X	X	X	X
Housing Deposits	X	X	X	X	X
Housing Tenancy & Sustaining Services	X	X	X	X	X
Short-Term Post-Hospitalization	X	X	X	X	X
Recuperative Care (Medical Respite)	X	X	X	X	X
Respite Services	X	X	X	X	X
Day Habilitation Programs	X	X	X	X	X
Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities	X	X	1/1/2024	X	1/1/2024
Community Transition Services/Nursing Facility Transition to a Home	X	X	X	X	X
Personal Care and Homemaker Services	X	X	X	X	X
Environmental Accessibility Adaptations (Home Modifications)	X	X	7/1/2023	X	7/1/2023
Medically Tailored Meals/Medically-Supportive Food	X	X	X	X	X
Sobering Centers	X	X	X	7/1/2023	X
Asthma Remediation	X	X	X	X	X

DHCS menu of options: The 14 Community Supports

Housing transition Navigation services	Housing deposits (Move-In assistance)	Housing tenancy and sustaining services	Short-term post hospitalization housing
Recuperative care (Medical respite)	Respite (For caregivers)	Day habilitation programs	Nursing facility transition/diversion to assisted living facilities
Nursing facility transition to a home	Personal care and homemaker services	Environmental accessibility adaptions (home modifications)	Meal/medically tailored meals
	Sobering centers	Asthma remediation	

MOLINA® HEALTHCARE

Referral and authorization process



How to refer a member?

CS Referrals

There is a separate CS referral form specific to each CS service and different instructions on where to fax the referral.

Send the completed referral form to 8008114804@fax2mail.com

For Recuperative Care and Short-Term Post Hospitalization **866-533-9263**

ECM Referrals

Submit referral form to **MHC_ECMReferrals@molinahealthcare.com**

5 business day turnaround for processing and response. If referral is more urgent, please indicate URGENT in subject line when sending the referral and allow up to 72 hours. Most urgent requests are processed same day.

We accept all ECM referral forms, including the Sac Universal Referral Form.

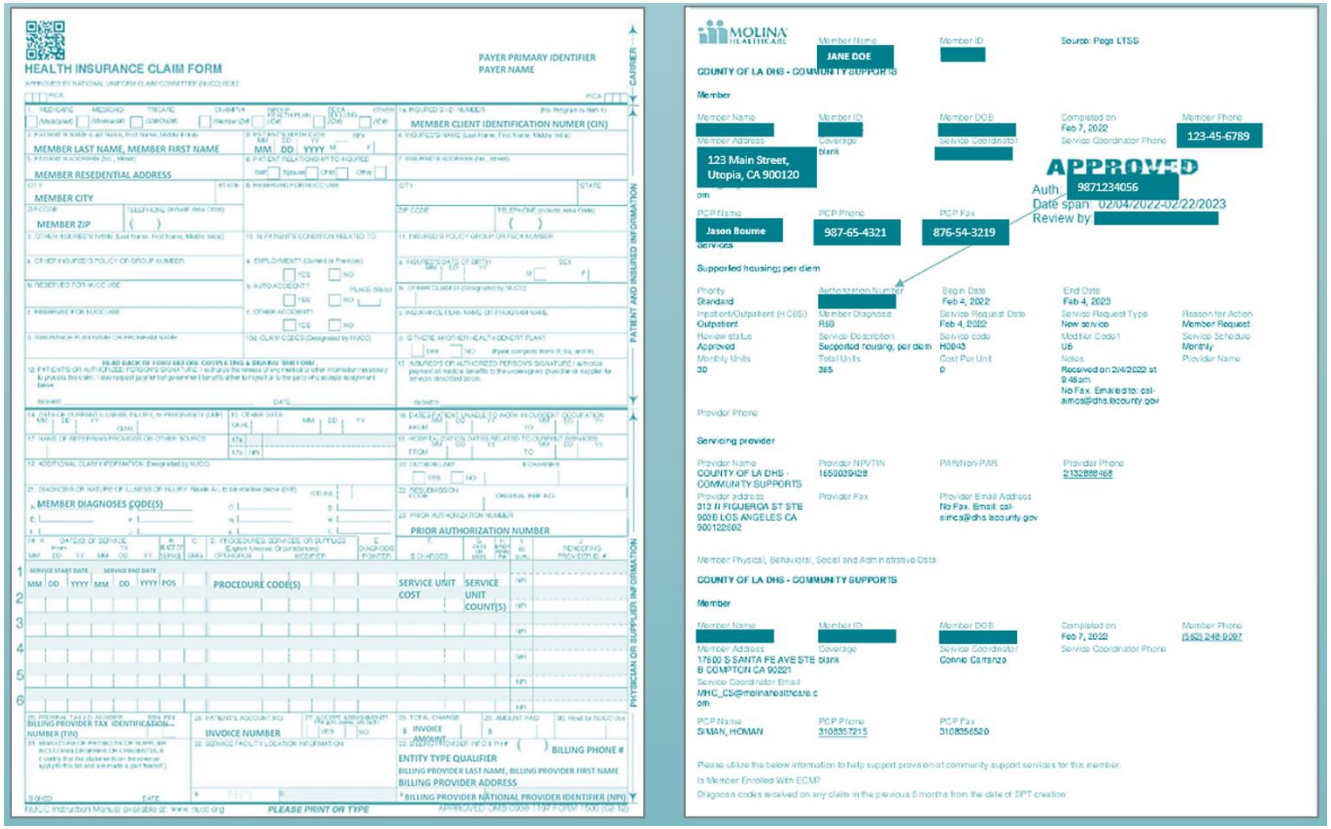
ECM and CS Referral Forms are available on Molina's public website, located in the provider section, under Frequently Used Forms:

https://www.molinahealthcare.com/providers/ca/medicaid/forms/fuf.aspx

MOLINA® HEALTHCARE

Community Supports claims

- Providers are requested to submit claims on CMS-1500.
- More information at https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500.
- Please ensure that the “billing provider name” in Box 33 in your “PayTo Name {a space}{a dash}{a space}CS”. This will aid claims being linked to the correct provider contract, which has been configured.
- All claims must be submitted within 90 days of the date of service. Any corrected claims must also be submitted within 90 days of the date of service.
- Molina Healthcare of CA will accept invoices from CS provider who do not have the technical capabilities to generate a claim. However, at a minimum, CA DHCS required that provider submit information related to the minimum data elements in their invoices, which are in **colored font** on the CMS-1500 image.



Community Supports claims, cont.

- Claims codes
  - Diagnosis codes: Enter the appropriate diagnosis code(s) in box 21A-L on the CMS-1500 claim form. Enter the correspondence diagnosis pointer code indicated in box 21 A-L in box 24 E for every service line entered.
  - Place of service code: Enter the appropriate place of service code in 24 B. The place of service code list can be found in the following CMS website:
    - https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set
  - Procedure codes: Enter the procedure code that has been approved using the appropriate HCPCS code, unity, and modifier, based on the description in the following table. Enter the codes in 24 D-G

Description	HCPCS Code	Units Description	Modifier To Use	Routine Authorization Timeframe*	Initial Max Units to Authorize
Housing Transition/Navigation Services: Supported housing, per month	H0043	1 unit = 1 day (monthly case rate)	U6	Initial 12 months and 6 months thereafter	365
Housing Deposits: Supported housing, per month. Requires deposit amounts to be reported on the encounter.	H0044	1 unit = 1 month	U2	6 months	6
Housing Tenancy and Sustaining Services: Support brokerage, self-directed; per month	T2041	1 unit = 15 mins (monthly case rate)	U6	Initial 12 months and 6 months thereafter	35040
Short-Term Post-Hospitalization Housing: Supported housing; per month. Modifier used to differentiate Short-Term Post Hospitalization Housing from Housing Deposits.	H0044	1 unit = 1 month	U3	3 months	3
Recuperative Care: Residential care, not otherwise specified, waiver, per diem	T2033	1 unit = 1 day	U6	Monthly	30
Respite Services – Home: Respite care, in the home; per diem	S9125	1 unit = 1 hour	U6	Daily for 4 hours and dependent on need.	4
Day Habilitation Programs: Skills training and development; per 15 minutes	H2014	1 unit = 15 mins	U6	24 hours per 6 months	96
Community Transition Services/Nursing Facility Transition to a Home: Community transition, per service. Requires billed amount(s) to be reported on the encounter.	T2038	1 unit = 1 month (monthly case rate)	U5	6 months	6
Personal Care/Homemaker Services: Personal care services; services, per hour	T1019	1 unit = 15 minutes	U6	Daily for 4 hours and dependent on need.	16
Medically-Supported Food/Medically Tailored Meals: Home delivered meal	S5170	1 unit = 1 delivered meal	U6	Up to 4 weeks	56
Sobering Centers: Alcohol and/or drug services; ambulatory detoxification	H0014	1 unit = 1 day	U6	Daily	1
Asthma Remediation: Home modifications; per service	S5165	1 unit = 1 service	U5	6 months	12 (2 units per month)

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Community Supports claims, cont.

- **Corrected claims:**
  - Must be free of handwritten or stamped verbiage (paper claims).
  - Must be submitted on a standard red and white UB-04 or CMS-1500 claim form (paper claims).
  - Original claim number must be inserted in field 64 or the UB-04 or field 22 of the CMS-1500 of the paper claims, of the applicable 837 transaction loop for submitting corrected claims electronically.
  - The appropriate frequency code/resubmission code must also be billed in field 4 of the UB-04 and 22 of the CMS-1500.
    - **Note:** The frequency/resubmission codes can be found in the NUCC (National Uniform Claim Committee) manual for CMS-1500 Claim forms of the UB Editor (Uniform Billing Editor) for UB-04 claim forms.

- **Modes of submission:**
  - Claims may be submitted electronically through either Availity or the Provider Portal for those who have an existing account. Please note that Molina will be transitioning completely to Availity, therefore it is encouraged to register and use the Availity platform for electronic submissions.
    - **Electronic:** Availity at https://provider.molinahealthcare.com/Provider/Login , or
    - Alternatively, providers may also utilize our clearinghouse, Change Healthcare, for submission, as follows:
      - Change Healthcare (CH),
      - CH's Telephone #: 1-877-469-3263,and
      - Molina's Payer ID # with CH is: 38333.

Mail to: Molina Healthcare, Inc.
P.O. Box 22667
Signal Hill Post Office
2371 Grand Avenue
Long Beach, CA 90809

MOLINA® HEALTHCARE

Services for seniors and people with disabilities

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Developmental disability services (DDS)

Developmental disabilities services are managed through the regional center for members who are either:

- Age 36 months to 18 years old, who have a developmental delay in either cognitive, communication, emotional, adaptive, physical, or motor development, including vision and hearing, or a condition known to lead to developmental delay, or those in whom a significant developmental delay is suspect, or whose early health history place them at risk for delay.
- Members who are at risk of parenting a child with a developmental disability.

Who is eligible for the regional center?

- To be eligible for services, a person must have a disability that begins before the person's 18th birthday, be expected to continue indefinitely and present a substantial disability as define in Section 4512 of the California Welfare and Institution Code. Eligibility is established through diagnosis and assessment performed by the Regional Centers.
- Infants and toddlers (age 0-36 months) who are at risk of having developments disabilities or who have a developmental delay may also qualify for services. The criteria for determining the eligibility of infants and toddlers is specified in Section 95014 of the California Government Code. In addition, individuals at risk of having a child with a developmental disability may be eligible for genetic diagnosis, counseling and other prevention services. For information about these services, see Early Start.

Developmental disability services (DDS)

Determine eligibility

- Infants and toddlers from birth to age 36 months may be eligible for early intervention services through Early Start if, through documented evaluation and assessment, they meet one of the criteria listed below:
  - Have a developmental delay of at least 33% in one or more areas of either cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing; or,
  - Have established risk condition of known etiology, with a high probability of resulting in delayed development; or,
  - Be considered at high risk of having a substantial developmental disability due to a combination of biomedical risk factors of which are diagnosed by qualified personnel California Government Code: Section 95014(a); California Code of Regulations: Title 17, Chapter 2, Section 52022

PCP Screening

- The PCP shall complete an intake and assessment for members aged 0-36 months with, or suspected to have a developmental disability:
- Children shall receive a complete medical evaluation to confirm the diagnosis and determine the genetic and/or non-genetic etiology. This may include, but not limited to:
  - Prenatal/perinatal history
  - Developmental history
  - Family history
  - Metabolic and chromosomal studies
  - Specialty consultations as indicated

Developmental disability services (DDS)

Referrals to the regional center

- Referrals are made directly to the intake screener of the regional center (RC).
- Submit the referral to the RC as soon as possible.
- Please include:
  - Reason for referral
  - Complete medical history and physical examination, including appropriate developmental screens.
  - Results of developmental assessments/psychological evaluation and other diagnostic tests as indicated.

Services provided by the regional center

- Some of the service and supports provided by the regional centers include:
  - Information and referral
  - Assessment and diagnosis
  - Counseling
  - Lifelong individualized planning and service coordination
  - Purchase of necessary services included in the individual program plan
  - Resource development
  - Outreach
  - Assistance in finding and using community and other resources
  - Advocacy for the protection of legal, civil and service rights
  - Early intervention services for at risk infants and their families
  - Genetic counseling
  - Family support
  - Planning, placement, and monitoring for 24-hour out-of-home care
  - Training and education opportunities for individuals and families
  - Community education about developmental disabilities

Clinical protocols and practice guidelines for seniors and persons with disabilities/chronic conditions

It is important to ensure that the Molina members we serve receive access to quality care that supports their individual health needs. Available services include:

- Transportation to medical appointments
- Coordination of medical, social, and mental health services
- Complex case management
- Improved member communications utilizing alternate formats
- Detailed information on accessibility of provider offices

How to find an accessible Molina provider:
https://www.molinahealthcare.com/providers/ca/medicaid/resource/ProviderFacilityReq.aspx

Molina's 24-Hour Nurse Advice Line:
https://www.molinahealthcare.com/providers/ca/medicaid/resource/NurseAdviceLine.aspx

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Population health cultural and linguistics health education

MOLINA® HEALTHCARE

Health education

Health management program and services

Program and services

- Asthma (2+ y.o)
- Diabetes (18+ y.o)
- Hypertension (18+ y.o)
- Heart failure (18+ y.o)
- Depression (18+ y.o)
- Adult weight loss management and obesity (18+ y.o)
- Nutrition consults (2+ y.o)
- Refer using the referral form:
- https://**www.molinahealthcare.com/providers/ca/medicaid/forms/fuf.aspx**
- Or have members call:
- 866-891-2320, ext: 751137, option 2

Smoking cessation

Refer to KICK IT CA

- For quitting smoking, vaping, and smokeless tobacco
- Counseling is available in multiple languages (English, Spanish, Korean, Vietnamese, Cantonese and Mandarin).
- NRTs covered by Molina
- 10 – days of patches available via KICK IT for qualifying members (for members 18+)
- Speak with a Quit Coach
- 800-300-8086 (English)
- 800-600-8191 (Spanish)
- Chat with a Quit Coach
- Kickitca.org/chat

Diabetes prevention program

Contract with Teladoc Health

- For members 18+
- Pending DHCS approval
- In the interim, refer to the Health Management programs as appropriate

Maternal mental health

Prenatal and postpartum care

- Use a validated screening tool (PHQ-9, EPDS)
- G8431 (positive) and G8510 (negative)* with modifier HD for Medic-Cal members.
- Refer to a network mental health provider or County MH provider.
- Molina High-Risk OB program includes:
- Risk Screening
- Clinical case management
- Member Education
- Refer: 866-891-2320
- WeConnect app – Medi-Cal (Sac, SD, Riv, SB)
- Dx of SUD, OUD, or mental behavioral health conditions.
- Refer: https://hipaa.jotform.com/213005264240137

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Interpretation services

Interpretation Services

Telephonic Interpreters

- Available on demand, 24/7.
- Telephonic interpretation is best for most routine appointments.
- Call the Contact Center to be immediately connected to an interpreter. No appointment needed!
- Over 125 languages
- Providers can access interpreter services via Molina Member and Provider contact center.

Video Remote Interpreters

- VRI is best for more complicated appointments or when the member needs access to a sign language interpreter.
- VRI is HIPAA compliant. It can be accessed from any standard smartphone, tablet, or laptop equipped with a webcam and requires no special software.
- Appointments should be scheduled at least 2 days in advance whenever possible.
- On-demand VRI is also available as a backup.

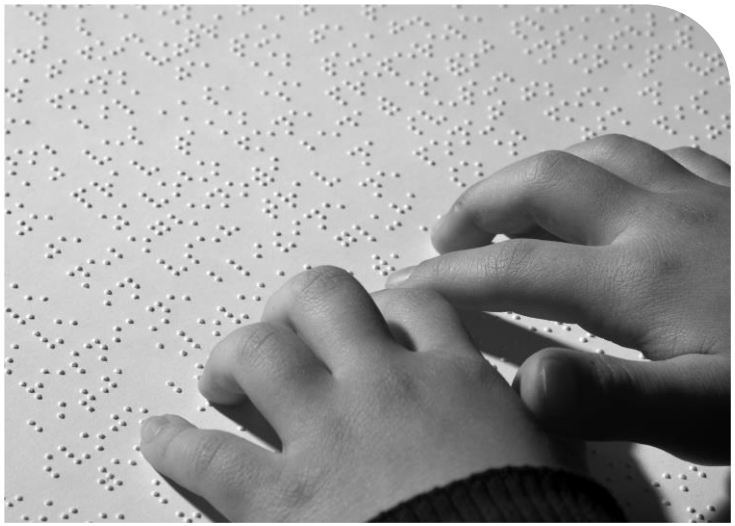
In-Person Interpreters

- In-person interpretation is used for the most complex appointments, or when VRI is not possible.
- Appointments should be scheduled at least 5 days in advance whenever possible.
- Telephonic interpretation and VRI are both available as backups in case the in-person interpretation is not approved, or the interpreter does not show

Cultural and linguistic services

Translation

- Molina translates existing health education materials, care plans, and enrollment materials into the member's preferred language upon request.
- Molina offers a variety of low literacy health education materials in English and Spanish online at: https://www.molinahealthcare.com/providers/ca/medicaid/resource/Health-Education-Materials.aspx



To access Interpretation Services:

- Call Molina's Provider Contact Center at (855) 322-4075
- For after-hours and weekends, please call Molina's Nurse Advice Line to connect to an interpreter (888) 275-8750.
- To speak to members who are deaf, hard of hearing, or have a speech difficulty, providers may use the California relay service. Dial 711 and give the relay operator (RO)/communication assistant (CA) the member's area code and telephone number.

Alternate format

- Molina offers vital documents in large print, Braille, electronic files, and audio format.

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Cultural and linguistic training and resources

- Molina offers Cultural Competency training videos on our website: https://www.molinahealthcare.com/providers/ca/medicaid/resource/cme.aspx
- Additional resources on the Molina website include the provider education series of brochures on service members with disabilities: https://www.molinahealthcare.com/providers/ca/medicaid/resource/cme.aspx
- Molina also offers tailored training on cultural competency and sensitivity to seniors and persons with disabilities. For cultural and linguistic consultations, questions regarding cultural beliefs and practices that may affect patient care, or to request training, contact Molina: HealthEducation.MHC@molinahealthcare.com
- Molina's "Ask the Cultural and Linguistics Specialist" page is an interactive web-based question-and-answer forum on providing culturally appropriate care. All inquiries receive a response within 72 hours from Molina's Cultural Anthropologist. To access, go to our provider website: https://www.molinahealthcare.com/providers/ca/medicaid/resource/ask_cultural.aspx

Language Rights and the Law

Sections 1557 of the Affordable Care Act (ACA) requires that all limited English proficient (LEP) beneficiaries' language access needs be met for all medical appointments.

- To refuse an LEP beneficiary access to language services is a violation of that individuals civil rights.
- The ACA also prohibits providers from requesting a beneficiary to provide his or her own interpreter or rely on a staff member who is not qualified to communicate directly with the LEP individual.
- Please remember it is never permissible to ask a minor, family member, or friend to interpret.
- Molina complies with all guidance set forth in the ACA, Title VI of the Civil Rights Act, and CA SB 223, which includes instructions for accessing language services in significant member materials.

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Health education resources

Phone: (866) 891-2320

Monday to Friday, 8:30 a.m. - 5:30 p.m.

Fax: (800) 642-3691

Email: HealthEducation.MHC@MolinaHealthcare.com

Health education materials: https://www.molinahealthcare.com/providers/ca/medicaid/resource/Health-Education-Materials.aspx

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Health management programs

Health management programs

- Molina's health management programs provide patient education information to members and helps facilitate provider access to these chronic disease programs and services.
- For more information about the health management programs, please call the Provider Contact Center at (855) 322-4075.

Breathe with EaseSM Program

- Molina Healthcare provides an asthma health management program called breathe with ease, designed to assist Members in understanding their disease. The program educates the member and family about asthma symptom identification and control.

Building Brighter Days adult depression management program

- The Building Brighter Days depression management program is a collaborative team approach comprised of health education, clinical case management and provider education. The overall goal is to provide better overall quality of life, quality of care and better clinical outcomes for members who have a primary psychiatric diagnosis of major depressive disorder.

Health management programs

Tobacco prevention and cessation services

- All providers are required to identify and track all tobacco use, both initially and annually.
- All providers are also required to institute a tobacco user identification system to identify tobacco users in their primary care practice, per USPSTF recommendations.

Services for pregnant tobacco users

- Pregnant beneficiaries should be offered tailored, one-on-one counseling exceeding minimal advice to quit.

Prevention of tobacco use in children and adolescents

- Providers are required to: Provide interventions, including education or counseling, in an attempt to prevent initiation of tobacco use in school-aged children and adolescents.

Smoking cessation resources

https://www.molinahealthcare.com/providers/ca/medicaid/resource/smoking-cessation.aspx

Health management programs

Weight management

- Molina's weight management program is comprised of one-on-one telephonic education and coaching by a health educator to support the weight management needs of the member.
- The health education staff work closely with the member's provider to implement appropriate intervention(s) for members participating in the program.

Diabetes prevention program

- Molina Healthcare offers the diabetes prevention program (DPP) to eligible members. The DPP is an online lifestyle change program that focuses on member engagement and health outcomes and is recognized by the Centers for Disease Control and Prevention (CDC).

Health education resources

Health education materials

- Appropriate use of health care services
- Risk reduction and healthy lifestyles
- Self-care and management of health conditions

https://bit.ly/3NB3Ewj

Health education forms

- Health education referral form
- Health education services flyer

https://bit.ly/3sSWQm1

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Diversity, Equity, and Inclusion

Diversity, Equity, and Inclusion training (formerly Cultural Competency)

Provider training

- Module 1: Introduction to Cultural Competency
- Module 2: Health Disparities
- Module 3: Specific Population Focus – Seniors and Persons with Disabilities
- Module 4: Specific Population Focus – LGBTQ and Immigrants/ Refugees
- Module 5: Becoming Culturally Competent
- Provider Training Attestation Form

Provider resources on gender-affirming care

- Quality Interactions
- National LGBTQIA+ Health Education Center
- San Mateo Pride.org
- LGBTQIA+/2S Collaborative
- UCSF Lesbian, Gay, Bisexual, and Transgender Resource Center

Molina provider education series

- Americans with Disability Act (ADA)
- Members who are Blind or have Low Vision
- Service Animals
- Tips for Communicating with People with Disabilities & Seniors
- Health Resources for LGBTQ+ Members

Ask Molina's Cultural and Linguistics Specialist

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Diversity, Equity, and Inclusion training (formerly Cultural Competency)

Building culturally competent health care: Training for health care providers and staff

1. Think cultural health (HHS Office of Minority Health)
   - A Physician's Practical Guide to Culturally Competent Care
   - Culturally Competent Nursing Care: A Cornerstone of Caring
2. Industry Collaboration Effort (ICE) Cultural Competency Training for Healthcare Providers
3. Industry Collaboration Effort (ICE) Better Communication, Better Care
4. Teach Back Method
5. Culturally and Linguistically Appropriate Service Standards
6. Americans with Disabilities Act
7. The Arc
8. Virginia Commonwealth University Life Expectancy Mapping
9. Robert Wood Johnson Foundation Life Expectancy by Zip Code

Model of Care

Model of Care (MOC)

Course overview

- The Model of Care is the plan for delivering coordinated care and care management to special needs members and provided the basic framework under which we meeting the regulatory requirements as defined by the Centers for Medicare and Medicaid Services (CMS).

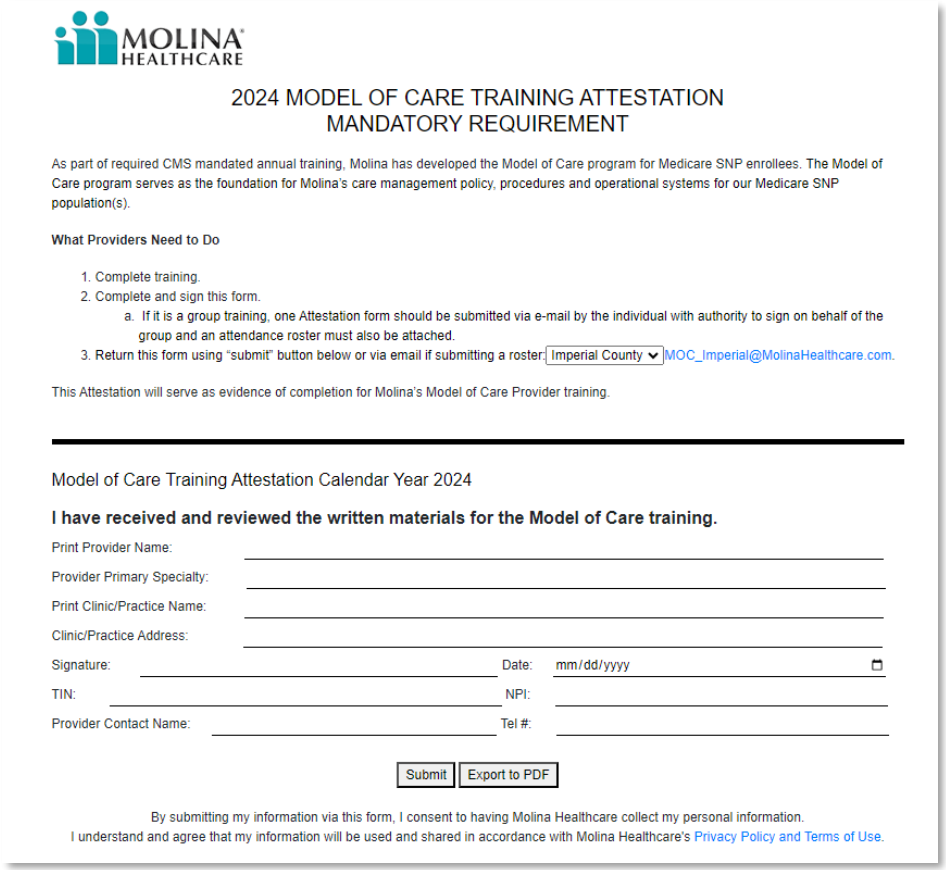
- All contracted Medicare PCPs and key high-volume specialists and certain delegates are required to complete MOC training annually.
  - Key high-volume specialists: Cardiologists, Hematology & Oncology, and Psychiatry

- This training will identify how you, as a provider of care, will support the MOC, while understanding CMS requirements for managing those members.

MOC – Training and attestation

Training Materials

- 2024 Model of Care Provider Training Quick Reference Guide
- 2024 Model of Care Provider Training
- 2024 Model of Care Attestation



MOLINA HEALTHCARE

2024 MODEL OF CARE TRAINING ATTESTATION
MANDATORY REQUIREMENT

As part of required CMS mandated annual training, Molina has developed the Model of Care program for Medicare SNP enrollees. The Model of Care program serves as the foundation for Molina's care management policy, procedures and operational systems for our Medicare SNP population(s).

What Providers Need to Do

1. Complete training.
2. Complete and sign this form.
   a. If it is a group training, one Attestation form should be submitted via e-mail by the individual with authority to sign on behalf of the group and an attendance roster must also be attached.
3. Return this form using "submit" button below or via email if submitting a roster: Imperial County MOC_Imperial@MolinaHealthcare.com.

This Attestation will serve as evidence of completion for Molina's Model of Care Provider training.

Model of Care Training Attestation Calendar Year 2024

I have received and reviewed the written materials for the Model of Care training.

Print Provider Name:
Provider Primary Specialty:
Print Clinic/Practice Name:
Clinic/Practice Address:
Signature: Date: mm/dd/yyyy
TIN: NPI:
Provider Contact Name: Tel #:

Submit Export to PDF

By submitting my information via this form, I consent to having Molina Healthcare collect my personal information.
I understand and agree that my information will be used and shared in accordance with Molina Healthcare's Privacy Policy and Terms of Use.

MOLINA HEALTHCARE

Pharmacy

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Pharmacy benefit management (PBM): Medi-Cal

- Prescription drugs are covered by Molina Healthcare through the Medi-Cal Pharmacy Benefit carve-out to Medi-Cal Rx (MRx)

- Drug list information, including the following, can be found online:
  - Physician administered drug list
  - Drug formulary
  - Medication prior authorization criteria
  - https://medi-calrx.dhcs.ca.gov/provider/drug-lookup

Pharmacy benefit management (PBM): Medicare and Marketplace

- Prescription drugs for Medicare and Marketplace lines of business are covered by Molina Healthcare through the CVS Caremark Pharmacy Network.
- A list of in-network pharmacies are available on the www.MolinaHealthcare.com website, or by contacting Molina at (855) 322-4075.
- Drug list information, including the following, can be found online:
  - Physician administered drug list
  - Drug formulary
  - Medication prior authorization criteria
  - https://www.molinamarketplace.com/marketplace/ca/en-us/Providers/Drug-List

Transportation services

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Transportation services

Emergency medical transportation

- Emergency transportation (ambulance), or ambulance transport services, provided through the “911” emergency response system, will be covered when medically necessary.

Non-medical transportation (NMT)

- NMT is covered for medically necessary covered services. NMT is transportation by car, taxi, or other public or private way of getting to your medical appointment.

Non-emergency medical transportation (NEMT)

- NEMT is covered for medically necessary covered services. NEMT is transportation by ambulance, litter van, wheelchair van, or air.
- A primary care physician or specialist will need to complete a provider certification statement form before the member receives NEMT services. The Physician Certification Statement form can be downloaded at:

  http://www.molinahealthcare.com/providers/ca/medicaid/forms/Pages/fuf.aspx

  https://molina.americanlogistics.com/

Scheduling transportation services

- Please call American Logistics Transportation at (844) 292-2688 at least three (3) business days (Monday to Friday) before the scheduled appointment or schedule the appointment online.

  https://molina.americanlogistics.com/

MOLINA® HEALTHCARE

Member rights and responsibilities

Member rights and responsibilities

Providers are required to comply with member rights and responsibilities as outlined in the provider manual.

Member rights include but are not limited to the following:

- Ask questions.
- If members do not agree with their provider's plan of care, they have the right to a second opinion from another provider.
- Let Molina or the state know about any fraud or wrongdoing.
- Be active in their health care.
- Entitled to confidential treatment of medical communication and records.
- Schedule appointments within the timely access standards
- Access to family planning services.
- Secure a copy of Molina's list of approved drug formulary.
- Submit a grievance.
- Decide in advance how you want to be cared for in case you have a life-threatening illness or injury.
- Get interpreter services on a twenty-four (24) hour basis at no cost to you. This service will help you to talk with your doctor or Molina if you prefer to speak a language other than English

MOLINA® HEALTHCARE

Provider rights and responsibilities

Provider responsibilities and information

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

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

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

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

MOLINA® HEALTHCARE

Questions?

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Index

The remaining slides are apart of the DHCS 2-year provider education requirement.

Health education resources

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MolinaHealthcare.com

Health Management Services

Provider Resources

Pregnancy Program

- To refer, complete and fax Molina's Pregnancy Notification Form to **(855) 556-1424**.
- LA County Medi-Cal members are eligible to participate in the pregnancy program offered by Health Net by calling **(800) 675-6110 (TTY: 711)**.

Smoking Cessation

Molina Healthcare collaborates with **Kick It California** to provide smoking cessation counseling.

Tobacco Cessation Services

- English: **(800) 300-8086** or Text "Quit Smoking" to **66819**
- Spanish: **(800) 600-8191** or Text "Dejar De Fumar" to **66819**
- Tobacco Chewers: **(800) 987-2908**
- Chinese: **(800) 838-8917**
- Korean: **(800) 556-5564**
- Vietnamese: **(800) 778-8440**

Vape Cessation Services

- English: Call **(844) 866-8273** or Text "Quit Vaping" to **66819**
- Spanish: Call **(800) 600-8191** or Text "No Vapear" to **66819**
- **Nicotine Replacement Therapy** - If an NRT requires a prior authorization, complete Prescription Drug Prior Authorization form and fax to **(866) 508-6445**.
- List of group counseling, support group or classes: **https://www.molinahealthcare.com/providers/ca/medicaid/resource/smoking-cessation.aspx**

Weight Management

- To refer, complete and fax Telephonic Health Education Referral form to **(800) 642-3691**.

MOLINA HEALTHCARE

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Nutrition Consults by a Dietitian

To refer, complete and fax the Telephonic Health Education Referral form to **(800) 642-3691** with provider nutrition prescription and supporting lab valuies.

Health Management Programs and Services

- Asthma
- Diabetes
- Adult Depression
- Heart Health
- COPD

To refer, complete and fax the Health Education Referral form to **(800) 642-3691**.

LA County Medi-Cal members may participate in the Disease Management programs offered by Health Net by calling **(800) 675-6110 (TTY: 711)**.

The above programs are available to Medi-Cal, Medicare, Cal MediConnect (MMP) and Marketplace members.

Diabetes Prevention Program

- Medi-Cal and Marketplace members
  - Refer to website to enroll. **http://www.yeshealth.com/molina**
- LA County Medi-Cal members
  - Refer to Health Net **(800) 675-6110** (TTY: **711**)

Health Education Materials

- Appropriate use of healthcare services
- Risk reduction and healthy lifestyles
- Self care and management of health conditions

Available in other languages and large font as requested.
https://www.molinahealthcare.com/providers/ca/medicaid/resource/Health-Education-Materials.aspx.

Health Education Forms and Resources

https://www.molinahealthcare.com/providers/ca/medicaid/forms/fuf.aspx.

- Telephonic health education referral form
- Staying Healthy Assessment (SHA) Form (in all threshold languages)
- Staying Healthy Provider Training Video
- Staying Healthy Provider Training Attestation Sign-In Form
- Alternate IHEBA Notification Form
- SHA Electronic or Other Format Notification Form
- Prescription Drug Prior Authorization Form

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Preventive health care services

Background

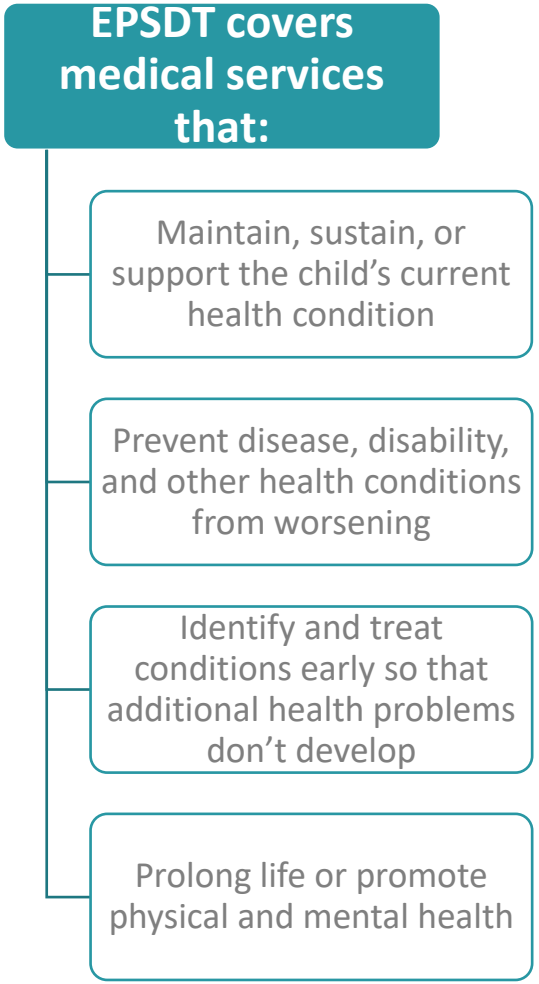
- The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit is a Federal preventive health and treatment service program that delivers periodic health assessments and comprehensive services to low-income children and youth enrolled in Medicaid.
- The EPSDT benefit is designed to treat and diagnose health problems in children as early as possible through early detection and regular check-ups.
- In California, EPSDT services are provided at no cost to individuals under age 21 with full-scope Medi-Cal.
  - The California Department of Health Care Services (DHCS) refers to the benefit as "Medi-Cal for Kids and Teens."
  - For more information on state-specific requirements, please reference the DHCS Medi-Cal for Kids and Teens Provider Training.
- Any qualified Medi-Cal provider (acting within their scope) may provide EPSDT services.

Early	Assessing and identifying problems early.
Periodic	Checking children's health at periodic, age-appropriate intervals.
Screening	Providing or arranging for screening services for medical, dental, vision, hearing, and mental health domains, including substance use disorders, developmental, and specialty services.
Diagnostic	Ensuring a complete diagnostic evaluation is rendered whenever potential risk is identified or a need for further evaluation and follow-up is required.
Treatment	Controlling, correcting, or improving health problems discovered by screening and diagnostic procedures through the provision of necessary health care services. Any service that "corrects or ameliorates" an identified condition must be covered under this benefit.

MOLINA® HEALTHCARE

EPSDT Program Specifics

- The Medicaid EPSDT program includes all services deemed medically necessary as follows:
  - Medical necessity under EPSDT includes services that "correct or ameliorate" defects and physical and mental illnesses or conditions.
  - This definition extends beyond the standard Medi-Cal medical necessity definition applied to adults, aiming to offer more expansive care for children and youth under age 21.
- The determination of whether a service is medically necessary for an individual child must be made on a case-by-case basis.
  - MHC considers all aspects of a child's needs, physical and mental, including nutritional, social development, mental health, and substance use disorders.
- The EPSDT benefit also covers care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.



MOLINA® HEALTHCARE

Initial Health Assessment Under EPSDT

- Members are encouraged by MHC to set up evaluations for initial health appointments (IHAs) and immunizations during the first 120 days of enrollment with MHC.
- MHC sends new members welcome letters and reminders advising them of this service.
  - Members will also receive written notice from their primary care provider (PCP) to prompt them to come in for needed immunizations.
- The IHA for members under age 21 is based on American Academy of Pediatrics (AAP) Bright Futures guidelines and includes the recommended childhood immunization schedule approved by the Advisory Committee on Immunization Practices (ACIP).
  - All pediatric and adolescent preventive visits must include age-specific assessments and services required by the AAP/Bright Futures under the EPSDT Program.

Components of a complete IHA include the following:

Health history
Unclothed physical “head-to-toe” examination
Developmental assessment
Nutritional assessment
Dental assessment of mouth, teeth, and gums and application of fluoride varnish when appropriate
Anticipatory guidance as delineated in the California Health Assessment Guidelines
Appropriate health education, including the harmful effects of using tobacco products and exposure to secondhand smoke
Vision testing
Hearing testing
Laboratory screening tests appropriate to age/sex (e.g., anemia, diabetes, and urinary tract infections)
Tuberculosis screening, with Tuberculin testing as appropriate
Sickle cell trait test, when appropriate
Blood lead test per California state guidelines
Immunization(

Covered Services

The DHCS requires that all Medi-Cal members from birth through their 20th year and 11 months receive periodic health screening exams at intervals that meet reasonable standards of medical practice.

California follows the nationally recognized pediatric periodicity schedule recommendations from the AAP's Bright Futures guidelines for well-child visits.

Well-child preventive care appointments should be scheduled **within seven working days** of a member's request.

Appropriate follow-up EPSDT services are to be initiated as soon as possible but **no later than 60 calendar days** following either a preventive screening or other visit that identifies a need for follow-up.

Screening Services

- Comprehensive health and developmental history, including assessment of both physical and mental health development.
- Unclothed "head-to-toe" physical examination.

Dental services

- At a minimum, dental services include relief of pain and infections, restoration of teeth, fluoride varnish as applicable based on age and maintenance of dental health.
- Dental services may not be limited to emergency services.

Health education

- Anticipatory guidance, including child development, healthy lifestyles, and accident and disease prevention.

Vision services

- At a minimum, diagnosis and treatment for defects in vision, including referral for eyeglasses.

Hearing services

- At a minimum, diagnosis and treatment for defects in hearing, including referral for hearing aids.

Diagnostic Services

- When a screening examination indicates the need for further evaluation of an individual's health, diagnostic services must be provided.

Laboratory tests

- As specified by the AAP, including screening for lead poisoning, as mandated by California regulations.

Treatment

- Necessary health care services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures, either directly provided or by referral.

Immunizations

- In accordance with the most current AAP, California and federal Childhood Immunization Schedule.

MOLINA® HEALTHCARE

Provider Responsibility

Providers are responsible for:

- Passing an on-site Facility Site Review (FSR) as part of the PCP credentialing process every three years.
  - The former CHDP review is folding into the FSR.
  - Members cannot be assigned until a facility has passed the review.
  - For more information, please review Chapter 29: Site Review Program of the MHC Medi-Cal Provider Manual.
- Ensuring members are up to date with immunizations and receiving all age-specific assessments and services.

California Children Services (CCS):

- The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions.
- If a CCS-eligible condition is identified as part of an EPSDT evaluation, providers are required to refer members to CCS on **the same day**.
- Once referred, CCS-paneled providers and practitioners will deliver care for the CCS-eligible condition.
- For further details on medical eligibility, refer to the DHCS Overview of CCS.

- Supervising practitioner extenders, ongoing care, and the coordination of care for all services that the member receives.
- Performing or referring members for diagnostic services when appropriate and without delay when further evaluation is needed.
- Providing or arranging treatment for the referral or provision of medically necessary treatment for physical and mental illness or conditions discovered by screening services.

CCS-Eligible Conditions
Chronic and complex medical conditions including but not limited to: • Cystic fibrosis • Hemophilia • Cerebral palsy • Heart disease • Cancer • Traumatic injuries • Congenital anomalies • Accidents, poisonings, violence, and immunization reactions • Infectious diseases producing major sequelae

MOLINA® HEALTHCARE

Dental

- Members should be referred annually to the appropriate Medi-Cal Dental Program providers for routine dental care starting at one year of age.
  - In addition, providers should provide fluoride varnish all eligible children under age six.
- Dental screenings/oral health assessments are part of the IHA and must be conducted during every periodic assessment.
  - Dental services, with the exception of dental screenings, are carved out of the MHC contract to the DHCS Medi-Cal Dental Program.
- The Molina Pediatric Case Management Department assists in making referrals for carve-out programs, such as dental.
  - MHC will provide prior authorization for medical services required in support of dental procedures.

Providers must:

Initiate an initial dental exam referral to a Medi-Cal-approved dentist with the eruption of the child's first tooth or at 12 months of age, whichever occurs first.

Conduct a dental assessment (including fluoride varnish application if age-appropriate) to check for normal growth and development and for the absence of tooth and gum disease.

- This assessment should occur at the time of the IHA and at each EPSDT examination visit, according to the periodic health examination schedules.

Annually refer members directly to a dentist or through the Medi-Cal Dental Program.

- Contact the Medi-Cal Dental Program at (800) 322-6384 or review the Medi-Cal Provider Directory to find dental providers that are currently accepting new members.

MOLINA® HEALTHCARE

Immunizations

- The provision of immunizations is an essential component of comprehensive periodic health assessments required for members under age 21.
- Immunization services may be accessed during any PCP visit.
  - MHC does not require rescheduling of visits for immunizations if it is identified, at an acute visit that a child needs immunizations, unless the child has a medical contraindication to receiving immunizations at the time of their visit to the PCP.
- When a member experiences complications from an immunization (e.g., infection or abscess), members should contact their PCP for follow-up care just as they would with any other medical condition or concern.
  - Upon request, the Local Health Department (LHD) will provide technical assistance, training, and material related to immunizations for MHC providers.

At each visit, providers are expected to:

1. Inquire if the member has received immunizations from another provider.
2. Educate members regarding their responsibility to inform their PCP if they receive immunization elsewhere, i.e., non-plan providers/practitioners, LHD, etc.
3. Administer immunizations to patients upon request during routine office hours.
4. Update the immunization card supplied by the LHD.
5. Follow the ACIP/AAP childhood immunization requirements and schedule.
6. Participate in the Vaccines for Children (VFC) Program and the California Immunization Registry (CAIR).
7. Cooperate with out-of-network providers when requested to share member's immunization history.
8. Document all efforts in assessing the actual immunization status of the MHC member prior to any immunization.
9. Review MHC's Provider Bulletins for updated immunization information.

Documentation

Follow-Up

- For members who are a "no-show" at the time of their appointment(s), the member (parent/guardian) should be followed up with through a telephone call.
  - If necessary, a letter from the physician's office should be sent to schedule another appointment.
- Documentation of the telephone call or a copy of the letter must be maintained in the member's medical record.

Consent

- Physicians must obtain the voluntary written consent of the member (if over 18 years) or parent/guardian (if under 18 years) before performing an EPSDT exam.
- Consent is also required for any release of information.
- If the member or parent/guardian refuses to have the exam or any portion of the exam performed, this information must be documented in the member's medical record.

Referrals

- Covered EPSDT screening services **do not require** prior authorization.
- Once a medical, dental, nutritional, or developmental problem is identified during the EPSDT health exam, the child may need further diagnosis and/or treatment of that problem.
- If the child needs specialty care, the EPSDT provider is obligated to make the referrals to assist the family in coordinating the care their children need.
  - All referrals and medical justification for them should be documented in the child's medical record.
- Pediatric Medical Case Managers are available to provide care coordination if indicated and requested by the PCP or if a service is needed but cannot be covered by MHC.
- MHC cannot pay for non-covered services.
  - Providers must submit a Prior Authorization (PA) request through the Molina Availity Provider Portal to request services on the MHC PA matrix if needed as part of EPSDT services.
  - Any services that could be eligible for CCS need to be referred immediately to that program for coverage.

MOLINA® HEALTHCARE

Encounter/Claims Submission

Contact Information

The Molina EPSDT Services Department handles all EPSDT wellness services and collects data from PCP encounters/claims submissions for EPSDT incentive payments.

Address: Molina Healthcare of California
PO Box 16027
Mailstop "HFW"
Long Beach, CA 90806
Attn: EPSDT Department

Phone: (800) 526-8196

Fax: (562) 499-6117

Encounters

- All providers who deliver care to eligible EPSDT members must submit standard claim and/or encounter forms for EPSDT services.
- An encounter or claim must be completed for each child who receives an EPSDT health assessment.
- All encounters or claims forms must be complete and accurate.
- Incomplete or inaccurate encounters or claims forms will be rejected or denied.

Submission

- If a PCP is contracted with an IPA/Medical Group, the PCP should follow their respective IPA/Medical Group's data submission guidelines.
- All providers should submit timely claims and/or encounter data through normal and current reporting channels to ensure the receipt of incentive payouts by MHC.
- For more information on billing codes, please refer to the DHCS Medi-Cal For Kids and Teens Training.

MOLINA® HEALTHCARE

California Children's Service (CCS)

California Children's Services

- California Children's Services (CCS) is a state program for children with certain diseases or health problems. Through this program, children up to 21 years old can get the health care and services they need. The program arranges and pays for medical care, equipment and rehabilitation when these services are authorized by the program.
- The CCS program is administered as a partnership between county health departments and the California Department of Healthcare Services (DHCS).
- Examples of CCS eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae. CCS also provides medical therapy services that are delivered at public schools.
- The CCS program provides diagnostic and treatment services, medical case management, physical and occupational therapy service to children under age 21 with CCS eligible medical conditions.

CCS FAQ

- Apply to become a paneled CCS provider at: https://www.dhcs.ca.gov/services/ccs/Pages/CCSProviders.aspx

- For CCS referrals, please go to: https://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/dhcs4509.pdf

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Medi-Cal

- Not all hospitals are CCS paneled.
- Not all parts of the hospitals are CC paneled.
- If the patient is admitted to a non-CCS paneled hospital, CCS will not pay unless the patient is transferred to a CCS paneled hospital, or the hospital immediately notified CCS and received day to day approval to provide care until the patient can be transferred to a CCS paneled hospital.
- At least one of the physicians caring for the patient in the CCS paneled hospital must be CCS paneled.

MOLINA® HEALTHCARE

Health care and preventative care services for women and adults

MOLINA® HEALTHCARE

Health care and preventive care services for women and adults

Pregnancy and maternity care

All pregnant and postpartum women must be offered access to the Comprehensive Perinatal Services Program (CPSP) or equivalent services.

This includes the multidisciplinary integration of health education, nutrition, and psychosocial assessments. In addition, pregnant and postpartum women have access to the following:

Medical/obstetrical Care	Trimester reassessments
Genetic counseling	Postpartum assessment
Case coordination	Health education
Case management	Nutrition assessment
Individualized Care Plan (ICP)	Psychosocial assessment

Medical/obstetrical care will be provided to both the common and identified high-risk pregnancy/postpartum member within seven to 84 days postpartum.

Health care and preventive care services for women and adults

Provider/practitioner responsibilities:

CPSP certified providers/practitioners of perinatal services	Non-CPSP certified providers/practitioners of perinatal services
• CPSP certified providers/practitioners shall be responsible for providing and complying with all CPSP service requirements for their pregnant and postpartum members up to 60 days after delivery. • CPSP certified providers/practitioners shall be responsible for complying with MHC's policy and procedure and CPSP requirements and standard including use of appropriate assessment, documentation, and care planning tools; submission of reporting forms (i.e. pregnancy notification report. • All CPSP providers/practitioners will receive information on how to obtain copies of CPSP's "Steps to Take" materials which provide helpful information to staff members to effectively assess, provide intervention for common pregnancy related conditions/ discomforts and how to appropriately refer pregnant members to all appropriate services.	• Non-CPSP providers/practitioners must comply with MHC policy and procedures and standards including: • Use of appropriate assessment, documentation, and care planning tools: ○ Submission of reporting forms (e.g., pregnancy notification report) ○ Employment of appropriate, qualified staff (e.g., CPHW) • MHC's perinatal services staff may also perform audits/reviews on, but not limited to, the following: ○ Member satisfaction questionnaire ○ Member complaints

Health care and preventive care services for women and adults

Provider/practitioner responsibilities

OB care providers/practitioners are strongly encouraged to be CPSP certified or have a formal relationship with a CPSP certified provider/practitioner for the provision of CPSP support services. All pregnant members shall be referred and assigned to CPSP certified providers/practitioners for CPSP services, whenever possible. The CPSP providers/practitioners shall be involved with the following:

- Integration of clinical health education, nutrition, and psychosocial assessment.
- Medical obstetrical care, genetic counseling, and case coordination/management.
- Use of appropriate documentation and care planning tools.
- Submission of encounter and outcomes data.

As of July 1, 2019, AB 2193 maternal mental health requires a licensed health care practitioner who provides prenatal or postpartum care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions. A health provider must use a validated tool to assess the member's mental health, either in the prenatal or postpartum period, or both. Two examples are the Patient Health Questionnaire-9 (PHQ-9) and the Edinburgh Postnatal Depression Scale (EPDS).

Molina requires health care providers to document mental health screening for pregnant or postpartum members using the current CPT/HCPCS claim codes.

Health care and preventive care services for women and adults

Preventive care

- MHC requires contracted providers/practitioners of perinatal services to adhere at minimum to the current American College of Obstetrics and Gynecologists (ACOG) standards, current edition.
- MHC prenatal preventive care guidelines are derived from recommendations from nationally recognized organizations, such as the ACOG, U.S. Preventive Services Task Force, the American Academy of Family Physicians, and others. They are updated annually. Prenatal preventive care guidelines are available on the MHC webpage at: MolinaHealthcare.com.
- The MHC UM department shall be responsible for reviewing all referrals and treatment authorization requests for perinatal services of MHC members where prior authorization is required. Please refer to MHC's Prior Authorization Guide in the Health care Service Section.
- MHC providers/practitioners shall follow ACOG's guidelines for perinatal care regarding the frequency of visits/reassessments: Uncomplicated pregnancy
  - Every four weeks for the first 28 weeks
  - Every two to three weeks until the 36th week
  - After the 36th week, then weekly until delivery
  - Postpartum, three to eight weeks after delivery

Health care and preventive care services for women and adults

Preventive care

Nurse midwife services:

- Defined by Title 22, nurse midwife services are permitted under state law and are covered when provided by a Certified Nurse Midwife (CNM). MHC will provide access to and reimbursement for CNM services under state law. Federal guidelines have been established and members have the right to access CNM services on a self-referral basis.

Special supplemental nutrition program for Women, Infants & Children:

- The Women, Infants & Children (WIC) supplemental food program is a local county program that is available for eligible pregnant women, infants and children under 5. This program provides an evaluation and, if appropriate, a referral for pregnant, breastfeeding, or postpartum women or parents or guardians of a child under five years of age for services. Program services include nutrition assessment and education, referral to health care, and monthly vouchers to purchase specific food needed to promote good health for low-income pregnant, breast-feeding, and postpartum women, infants, and children under five years of age with a medical/nutritional need.

Program services:

- WIC participants receive a packet of food vouchers each month, which they can redeem at the local retail market of their choice, for supplemental food such as milk, eggs, cheese, cereal, and juice. WIC participants attend monthly nutrition and health education classes and receive individual nutrition counseling from registered dieticians and nutrition program assistance. WIC also refers participants to other health and social service programs. Federal law requires the WIC program to promote and support breast-feeding.

Health care and preventive care services for women and adults

Breast-feeding promotion, education, and counseling services

Postpartum women should receive the necessary breast-feeding counseling and support immediately after delivery. Assessment of breast-feeding support needs should be part of the first newborn visit after delivery.

Durable medical equipment (DME)

- Lactation management aids, classified as DME, are covered benefits for MHC members. Specialized equipment, such as electric breast pumps, will be provided to breast-feeding MHC members when medically necessary.

Human milk bank

- Medi-Cal benefits include enteral nutritional supplemental or replacement formulas when medically diagnosed conditions preclude the full use of regular food. The provision of human milk for newborns will be arranged in the following situations:
  - Mother is unable to breastfeed due to medical reasons and the infant cannot tolerate or has medical contraindications to the use of any formula, including elemental formulas

For information regarding human milk banks, please contact your local WIC office.

Health care and preventive care services for women and adults

Adult preventive care services guidelines

MHC implements programs to encourage preventive health behaviors which can ultimately improve quality outcomes. Preventive health guidelines (PHG) are updated annually and derived from recommendations from nationally recognized organizations, such as the U.S. Preventive Services Task Force, the American Academy of Pediatrics, the American Academy of Family Physicians, and others. The recommended services noted in the PHG are based on clinical evidence; however, providers/practitioners and members should check with the plan to determine if a particular service is a covered benefit.

- **Preventive health guidelines:**
  - See website (www.MolinaHealthcare.com) for current and updated guidelines
- **Clinical practice guidelines:**
  - See website (www.MolinaHealthcare.com) for current and updated guidelines

Health care and preventive care services for women and adults

Initial health assessments (IHA)

The primary care physician (PCP) has the principal role to maintain and manage their assigned members. The PCP conducts the IHA and provides necessary care to members and coordinates referrals to specialists and health delivery organizations as needed. The IHA is a comprehensive assessment that is completed during the member's initial encounter with a selected or assigned PCP and must be documented in the member's medical record. The IHA enables the member's PCP to assess and manage the acute, chronic and preventive health needs of the member.

Members are required to have an IHA within 120 days of enrollment with Molina Healthcare.

The goals of the IHA are to assist providers with:

- Identifying and tracking high-risk behaviors of members.
- Prioritizing each Member's need for health education related to lifestyle, behavior, environment, and cultural and linguistic needs.
- Initiating discussion and counseling regarding high-risk behaviors.
- Providing tailored health education counseling, interventions, referral, and follow-up.

IHA services

MOLINA® HEALTHCARE

Initial health assessments (IHA)

The primary care physician (PCP) has the principal role to maintain and manage their assigned members. The PCP conducts the IHA and provides necessary care to assigned members and coordinates referrals to specialists and health delivery organizations as needed. The IHA is a comprehensive assessment that is completed during the member's initial encounter with a selected or assigned PCP and must be documented in the member's medical record. The IHA enables the member's PCP to assess and manage the acute, chronic and preventive health needs of the member.

An Initial Health Assessment (IHA) within one-hundred-twenty (120) days of a member's enrollment or within periodicity timelines established by the American Academy of Pediatrics for ages two and younger, whichever is less. The IHA must include a history of the member's physical and mental health, an identification of risks, an assessment of need for preventive screens or services, health education, and the diagnosis and plan for treatment of any diseases.

The IHA for members under age 21 will be based on American Academy of Pediatrics (AAP) guidelines and will include the recommended childhood immunization schedule approved by the Advisory Committee on Immunization Practices (ACIP). These preventive visits must include age specific assessments and services required by the Child Health and Disability Prevention program (CHDP).

The IHA for members over age 21 will meet the guidelines addressed in U.S. Preventive Services Task Force (USPSTF) and recommendations delineated in MHC's Preventive Health and Clinical Practice Guidelines.

It Matters TO MOLINA

MOLINA HEALTHCARE

BHT/ABA treatment

Who can provide BHT/ABA

BCBA or licensed clinician Provider

- Provides all services types - main function is to supervise the program and 1:1 direct staff, and complete assessments.
- A QAS provider is recognized as a BCBA or other nationally certified/licensed individual who has experience and competence designing, supervising or implementing ASD treatment (ex. Physician, Clinical Social worker, MFT).

BCaBA or MA level provider (aka QAS professional)

- Provides 1:1 direct service, social skills, and parent consultation.

Uncertified provider (aka QAS paraprofessional)

- Provides direct 1:1 therapy to child.
- Can also provide parent consultation.
    - *Molina exception - Master's level uncertified individuals may provide 75% of supervision, and bill as a QAS professional
    - *The professional and paraprofessional must be supervised by the provider

Request for prior authorization

- Authorization for services should be requested using the Molina PA request and include all supporting clinical documentation.
- MHC will process all non-urgent requests in no more than 5 business days of the initial request.
- Upon receipt of prior authorization request, MHC will give the provider a Molina unique authorization number. This authorization number must be used on all claims related to the service authorized.
- Providers who request prior authorization approval for services can request to review the criteria used to make the final decision. Providers may request to speak to the medical director/BCBA who made the determination to approve or deny the service request.

Supervision policy

- Supervision may be done by a QAS provider 100%, or divided 75% by a QAS professional and 25% by a QAS provider.
- Molina will recognize a QAS provider as either a BCBA or other licensed/certified individual with competence and experience in implementing ABA/BHT.
- Molina will recognize a QAS professional as either a BCaBA or an uncertified/unlicensed individual that meets the following qualifications:
  - The uncertified/unlicensed individual must:
    - Conform to the Health and Safety code for minimum standard of experience.
    - Possess a Bachelor of Arts or Science Degree and have either:
      - 12 semester units in applied behavior analysis and one year of experience in designing and/or implementing behavior modification intervention services or
      - Two years of experience in designing and/or implementing behavior modification intervention services.
  - Or be registered as either:
    - A psychological assistant of a psychologist by the Medical Board of California or Psychology Examining Board; or an Associate Licensed Social Worker pursuant to business and professions code, section 4996.818.

Service codes

	Service type	Modifier	Billing increment
H0031	Assessments used for the FBA. (ex. VB-MAPP, Vineland)	AH, HP, HO, HN, HM	1 Hour
H0032	Development of the treatment plan (FBA)	AH, HP, HO	1 Hour
H2019	Direct 1:1 treatment	AH, HP, HO, HN, HM	15 Minutes
H0046	Supervision of the 1:1 direct staff	AH, HP, HO, HN,	1 Hour
S5111	Parent and/or other provider consultation	AH, HP, HO, HN, HM	15 Minutes
H20014	Social Skills group with multiple patients	AH, HP, HO	15 minutes
90791	Psych Evaluation	AH	1 visit
96101, 96111, 96116, 96118, 96120	Psych Testing	AH, HP, HO, HN, HM depending on code selected	Generally, 1 hour, may vary with code selected

Modifiers

Definition (Provider)	Billing Modifier	QAS Level
Licensed Clinician (MD, PhD, LCSW)	AH	Provider (QASP)
Doctoral Level Certified Provider (BCBA-D) Board Certified Behavior Analyst-Doctoral	HP	Provider (QASP)
Masters Degree Level Certified Provider (BCBA) Board Certified Behavior Analyst	HO	Provider (QASP)
Bachelors Degree Level Certified Provider (BCaBA) or bachelor's level qualified professional Board Certified Assistant Behavior Analyst	HN	Professional (QASPRO)
Unlicensed or uncertified Provider	HM	Paraprofessional (QASPARA)

Term definitions are as defined in the California Health and Safety Code § 1374.73

Behavioral health

MOLINA® HEALTHCARE

Behavioral health provider resources

- Through our partnership with Psych Hub, an online platform for digital mental health education, Molina network providers can access Psych Hub's library of educational courses and material at no charge. The available online training courses, called Learning Hubs, are designed to unlock a library of companion videos and resources and offer certification or continuing education credits upon completion.

- Continuing education credits are available to select clinical licensures (i.e., social workers, nurses, etc.) for many of the courses. Throughout this toolkit, you will see applicable courses available through the Psych Hub platform relevant to each topic. To create an account at no cost, please visit the Molina Psych Hub landing page.

- Provider can also visit our website to view our Behavioral Health Toolkit. We designed this Behavioral Health Toolkit for providers to offer guidance regarding mental health and substance use conditions commonly seen in the primary care and community setting.

MOLINA® HEALTHCARE

Behavioral health benefits overview

Covered by Molina all LOBs - No prior authorization (PA) needed with PAR provider

You may verify a service code on our PA look up tool

- Outpatient psychotherapy and psychiatry (90791, 90832, 90834, 90837, 90792, 99211, 99215) * no pre-set limits on sessions
- Outpatient family and group therapy (90847, 90853) *no pre-set limits on sessions
- Psychological and neuropsychological testing (96116, 966121, 96130, 96131, 96133, 96136, 93167, 96138, 96139, 96146) *first 4 hours, then PA needed

***Licensed, credentialed, PAR professionals and associates registered under their supervision may provide mental health services within their scope of practice and contract.**

MOLINA® HEALTHCARE

Behavioral health benefits overview

Prior auth needed for:

- Inpatient psychiatric & SUD rehabilitation: *authorized and covered by County Mental Health Plan for Medi-Cal
- Residential, partial hospitalization and intensive outpatient treatment for mental health and SUD *authorized and covered by County Mental Health Plan for Medi-Cal
- Eating disorder PHP, IOP, residential - service codes may overlap with some group therapy codes *Split risk between MCP and MHP for Medi-Cal
- Transcranial magnetic stimulation (TMS) (90867, 90868, 90869)
- Applied behavioral analysis (BHT/ABA) (H2019, S5111, H0031, H0032, H0046)

All services, treatment, and care by a non-par provider require prior authorization.

Behavioral health benefits overview

The “BH carve-out” applies to **Medi-Cal** members only.

- Substance Use Disorder (SUD) treatment outside of primary dare is authorized and covered by County Mental Health Plans (MHPs) and NOT Molina as a Managed Care Plan (MCP).
- **Medi-Cal members with SUDs who require treatment outside their primary care setting access services through the county carve-out.**

County	SUD Referral Number
San Bernardino	(888) 743-1478
Riverside	(800) 499-3008
San Diego	(888) 724-7240
Imperial	(800) 817-5292
Sacramento	(888) 881-4881
Los Angeles	(844) 804-7500

MOLINA® HEALTHCARE

Behavioral health benefits overview

The "BH carve-out" applies to **Medi-Cal** members only.

- MHP provides specialty mental health services (SMHS), while MCPs provide non-specialty mental health services (NSMHS)
  (Outpatient psychotherapy, psychiatry, and TMS CPT codes overlap in both systems)

A DHCS screening tool is required when Members directly contact the MCP or MHP, and they are not already receiving mental health care. The screening tool yields a score telling us which system of care to access for a particular member. Scores 6 and above go to MHP, while scores 5 and below go the MCP network. Medi-Cal members may be evaluated in either system of care and providers are not required to use the screening tool.

MOLINA® HEALTHCARE

Behavioral health benefits overview

The "BH carve-out" applies to **Medi-Cal** members only.

If a PAR BH provider assesses a member (they are treating) needs a higher level of care due to serious impairment caused by a mental health condition, a **DHCS Transition of Care Tool must be completed** and sent to the MHP. This form is narrative with no scoring mechanism. At Molina we ask providers to send the form to us so we can track the transition and make sure the member receives the services they need.

A provider may also send clinical justification in the body of an email, and our Molina staff may complete the DHCS tool on their behalf. In the email, providers should also let us know if services are termed or if they are continuing to provide "bridge" treatment. Our team will close the loop with the provider who has requested a transition. Members should be told by their provider that a transition is being requested and why.

Transition of care forms should be sent to: MHC_BH_Solutions@Molinahealthcare.com, with a subject line indicating *Step up to MHP from (provider name)*.

MHP= County Mental Health Plan; MCP= Managed care Plan (Molina

MOLINA® HEALTHCARE

Coordination of care

Coordination of care

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 assists providers by identifying needs and issues that may not be verbalized by members, assisting to identify resources such as community programs, national support groups, and appropriate specialists and facilities. Molina also works collaboratively with providers to identify best practices 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.

The Case Management Referral Form can be found on the Molina website. You can also refer to the Provider Manual for additional information.
Case management includes the following:

- For members 36 months to age 21 years old, providing or arranging for medically necessary diagnostic and treatment services necessary to correct and/or ameliorate conditions discovered in the screening process.
- Providing available medical documentation and reports, as requested, to the pediatric/RC case manager.
- Providing or arranging for medically necessary therapies and durable medical equipment.

Care coordination support

To refer a member for Complex Case Management, send a secure message to:

- Adults Medi-Cal: CMescalationCA@MolinaHealthCare.Com
- Pediatrics Medi-Cal and Marketplace: PedsCA@molinahealthcare.com
- Medicare: Medicare_CM_Team@Molinahealthcare.com
- Marketplace: CM_MPWest@molinahealthcare.com

You may attach this form to your email Link to Molina complex CM referral
Please visit our provider online directory to search for a provider.

To ask for help finding a mental health appointment, if your patient has no other outstanding care management needs, you may bypass the CM referral and call our BH Access Leads VM line. Providers may leave a detailed voicemail message at **(562) 549-4692**. The Behavioral Health team will contact the member the same day or the next day depending on the time they call. They will close the loop with you following member outreach.

***Members should call Molina Member Services. The voicemail line is not for distribution to members at this time.**

MOLINA® HEALTHCARE

Alcohol and drug screening, assessment, brief interventions and referral to treatment (SABIRT)

SABIRT

Requirement: PCPs must ensure unhealthy alcohol & drug screening (SABIRT) services are documented in the patient's medical chart/electronic medical record (EMR). Complete and accurate documentation is required to demonstrate compliance with Medi-Cal & Molina requirements.

How to screen all patient's unhealthy alcohol & drug use:

- Medi-Cal requires unhealthy alcohol and drug use for members 11 years of age & older, including pregnant women, using a validated screening tool, every year.
- When screening is positive, the provider must offer the member brief assessment, interventions and referral to treatment.
- Unhealthy alcohol and drug use screening must be conducted using validated screening tools. Validated screening tools include, but are not limited to: Cut down-annoyed-guilty-eye-opener adapted to include drugs (Cage-Aid); tobacco, alcohol, prescription medication and other substances (TAPS); National Institute on Drug Abuse (NIDA) quick screen; drug abuse screening test (DAST); alcohol use disorder identification test-consumption (AUDIT-C); partner, past, present (4Ps) for pregnant women; adolescents, car, relax, alone, forget, friends, trouble (CRAFFT) for non-pregnant adolescents; and Michigan alcoholism screening test geriatric (MAST-G) alcohol screening for geriatric population.
- Claim codes for screening & documenting a follow-up plan (for Medi-Cal):

SABIRT Billing Codes and Frequency Limits Table

Billing Code	Description	When to Use	Frequency Limit
G0442	Annual alcohol misuse screening, 15 minutes	Alcohol use screening	1 per year, per provider
H0049	Alcohol and/or drug screening	Drug use screening	1 per year, per provider
H0050+	Alcohol and/or drug services, brief intervention, per 15 minutes	Alcohol misuse counseling or counseling regarding the need for further evaluation/treatment	1 per day, per provider

SABIRT

How to assess patients when a screening is positive:

- When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or SUD is present. Validated alcohol and drug assessment tools may be used without first using validated screening tools. Validated assessment tools include but are not limited to: NIDA-modified alcohol, smoking and substance involvement screening rest (NM-ASSIST), drug abuse screening test (DAST-20), and alcohol use disorders identification test (AUDIT).

Brief interventions and referral to treatment:

- For recipients with brief assessments that reveal unhealthy alcohol use, brief misuse counseling should be offered. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered to recipients whose brief assessment demonstrates probable AUD or SUD. Alcohol and/or drug brief interventions include alcohol misuse counseling and counseling a member regarding additional treatment options, referrals, or services. Brief interventions must include the following:
  - Providing feedback to the patient regarding screening & assessment results
  - Discussing negative consequences that have occurred and the overall severity of the problem
  - Supporting the patient in making behavioral changes
  - Discussions and greeting on plans for follow-up with the patient, including referral to other treatment if indicated
- MCPs must make good faith efforts to confirm whether member receive referred treatments and document when, where, and any next steps following treatment. If a member does not receive referred treatments, the MASP must follow up with the member to understand barriers and make adjustments to the referrals is warranted. MCPs should also attempt to connect with the provider to whole the member was referred to facilitate a warm hand off to the necessary treatment.

Documentation:

- Member medical records must include the following:
  - The service provided, name of the screening instrument and score on the screening instrument, name of the assessment instrument and score on the assessment; and if and where a referral to an AUD or SUD program was made.

SABIRT

Documentation (continued):

- PCPs must maintain documentation of SABIRT services provided to members. When a member transfers from one PCP to another, the receiving PCP must attempt to obtain the member's prior medical records, including those pertaining to the provision of preventative services.
- Why unhealthy alcohol and drug use screening is critical:
- Unhealthy alcohol & drug use plays a contributing role in a wide range of medical and behavioral health conditions. Counseling interventions is the primary care setting can address risky drinking behaviors in adults by reducing weekly alcohol consumption and increasing long-term adherence to recommended drinking limits. Brief behavioral counseling interventions decrease the proposition of the persons who engage in episodes of heavy drinking. Additionally, brief counseling interventions increase the likelihood pregnant women will abstain from alcohol throughout their pregnancy. Effective treatment options for AUDs and/or substance use disorders depend on the severity of the disorder and include some combination of the following: alcohol and/or drug counseling sessions, participation in mutual help groups. Structured, evidence-based psychosocial interventions, Federal Drug Administration-approved medication, residential treatment (when medically necessary), or some combination of these services.

Resources:

- County alcohol and drug treatment referral lines and websites
  - Los Angeles: Substance Abuse Prevention & Control (SAPC) at: (888) 742-7900
  - LA County Department of Public Health - Substance Abuse Prevention and Control
  - San Bernardino: Substance Abuse Screening Assessment & Referral Center (SARC) at: (909) 421-4601
  - DBH Internet Website (sbcounty.gov)
  - Riverside: Substance Use CARES Line at: (800) 499-3008
  - Substance Abuse Prevention & Treatment Locations (rcdmh.org)
  - Imperial: Imperial County Access Unit at: (442) 265-1597 or (442) 265-1596
  - Sacramento: Sacramento County Access Team at: (916) 875-1055
  - San Diego: San Diego County Access & Crisis Line at: (888) 724-7240
  - Alcohol and Drug Services (ADS) (sandiegocounty.gov)

Emergency department protocol

MOLINA® HEALTHCARE

Emergency services definition

- **Emergency services** are services needed to evaluate or stabilize an **emergency medical condition.**
- An **emergency medical condition** is one where someone exhibits symptoms of severity – including severe pain – such that a prudent layperson with 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, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
  - Serious impairment to bodily functions, or
  - Serious dysfunction of any bodily organ or part

Prior authorizations	Notification requirements	Aftercare
• Emergency services under the above definition do not require MHC prior authorization. In accordance with California Department of Health Care Services' policies and current law, members presenting to an emergency room facility may be triaged by the emergency room staff, and MHC will pay the medical screening exam fee.	• MHC requires timely notification to the EDSU for any post stabilization services, i.e., inpatient admission. EDSU authorization requests should be communicated telephonically while the member is in the emergency room. EDSU's dedicated phone and fax number is used exclusively for members currently in the ER, to help expedite requests and assist with discharge planning.	• Aftercare instructions should be documented in the emergency facility medical record and communicated to the patient, parent, or guardian. Discharge from the emergency facility is performed on the order of a provider. For transfer requests and discharge planning authorizations, after hours, weekends and holidays, please contact the EDSU.

Emergency department support unit (EDSU)

The EDSU will collaborate with providers to ensure MHC members receive the care they need, when they need it.

EDSU 24/7 support:

- Assisting providers in determining appropriate level of placement using established clinical guidelines
- Issuing authorizations for post-stabilization care, transportation, or home health
- Involving a hospitalist or on-call medical director for any peer-to-peer reviews needed
- Working with pharmacy to coordinate medications or infusions as needed
- Obtaining SNF placement if clinically indicated
- Coordinating placement into case management with MHC when appropriate
- Beginning the process of discharge planning and next day follow-up with a primary care provider if indicated

To request authorization of post-stabilization services, call the EDSU at:
(844) 966-5462

To submit clinical records for authorization of post-stabilization care, fax the EDSU at:
(877) 665-4625

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Eligibility, enrollment and disenrollment

New members

- Molina Healthcare of California (MHC) receives EDI 834 benefit enrollment and maintenance transactions from DHCS and weekly Health Care Options (HCO) data files.
- The data received from HCO is matched to the processed EDI 834 and stored in MHC's core operating system.
  - MHC Availity Essentials Portal: provider.MolinaHealthcare.com
  - IPA/medical group eligibility list/Molina Healthcare Interactive Voice Response at (888) 665-4621
  - MHC's member services department at (888) 665- 4621
- If the member does not appear on the current eligibility roster, the provider/practitioner should contact MHC's provider contact center at (855) 322-4075
- At no time should a member be denied services because their name does not appear on the eligibility roster. Please remember that a member may access emergency services without prior authorization.

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Eligibility and eFiles

- Providers are encouraged to register and use the Molina's provider web portal as a primary method to check members' eligibility information: provider.molinahealthcare.com.

- The MHC interactive voice response (IVR) system notifies both providers/practitioners and members of member eligibility status and PCP assignment. The system has a dedicated phone line at (800) 357-0172 and is available 24 hours a day, 365 days a year.

- MHC distributes eligibility reports monthly to provide information on member enrollment in an IPA/medical group. The reports are generated the first week of each month and mid-month MHC Medi-Cal members who have changed providers/practitioners by the 15th of the month will be in effect for the currently calendar month.

- Members who have changed providers/practitioners on or after the 16th of the month will be in effect the first day the month following the next month. These files are secured, and password protected and can only be accessed by the IPA/medical group designee that are identified as the recipient. For additional details of the IPA/medical group eligibility list files, please contact your Provider Relations representative.

Member disenrollment

- Providers are encouraged to register and use the Molina's provider web portal as a primary method to check members' eligibility information: provider.molinahealthcare.com.
- Any member of MHC may at any time, without cause, request to be disenrolled from the plan. The member must contact HCO at (800) 430-4263. An HCO representative will mail a disenrollment form to the member's residence.
- A member with a mandatory aid code must simultaneously re-enroll into another managed care health plan.
- If the member fails to select a health plan, HCO will automatically assign them to one.
- Members who have a voluntary aid code may elect to remain in the Medi-Cal fee-for-service program or select a new health plan.
- Until the member's disenrollment request is approved and processed by DHCS, MHC will be responsible for the member's health care.
- **Disenrollment of a member is mandatory under the following conditions:**
  - Member requests to be disenrolled
  - Member loses Medi-Cal eligibility
  - Member moves out of the plan's approved service area
  - Member's Medi-Cal aid code changes to an aid code not covered
  - Member's enrollment violates the state's marketing and enrollment regulations
  - Member requests disenrollment as a result of a plan merger or reorganization
  - Member is eligible for those carve-out services that require disenrollment (see additional services or carve-out services).

Medical record documentation

MOLINA® HEALTHCARE

Medical records

- Molina requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to members is consistently documented and that necessary information is readily available in the medical record.
- All entries will be indelibly added to the member's record. PCPs should maintain the following components, that include but are not limited to:
  - Medical records confidentiality and release of medical records are maintained including behavioral health care records.
  - Medical record content and documentations standards are followed, including preventative health care.
  - Storage maintenance and disposal processes.
  - Process for archiving medical records and implementing improvement activities.
- Retrieval
  - The medical record is available to provider at each encounter.
  - The medical record is available to Molina for purposes of quality improvement.
  - The medical record is available to the applicable state and/or federal agency and the external quality review organization upon request.
  - The medical record is available to the member upon their request.
  - A storage system for inactive member medical records which allows retrieval within 24 hours, is consistent with state and federal requirements, and the record is maintained for not less than 10 years from the last date of treatment of for a minor, one year past their 20th birthday but, never less than 10 years.
  - An established and functional data recovery procedure in the event of data loss.

Medical record-keeping practices and organization

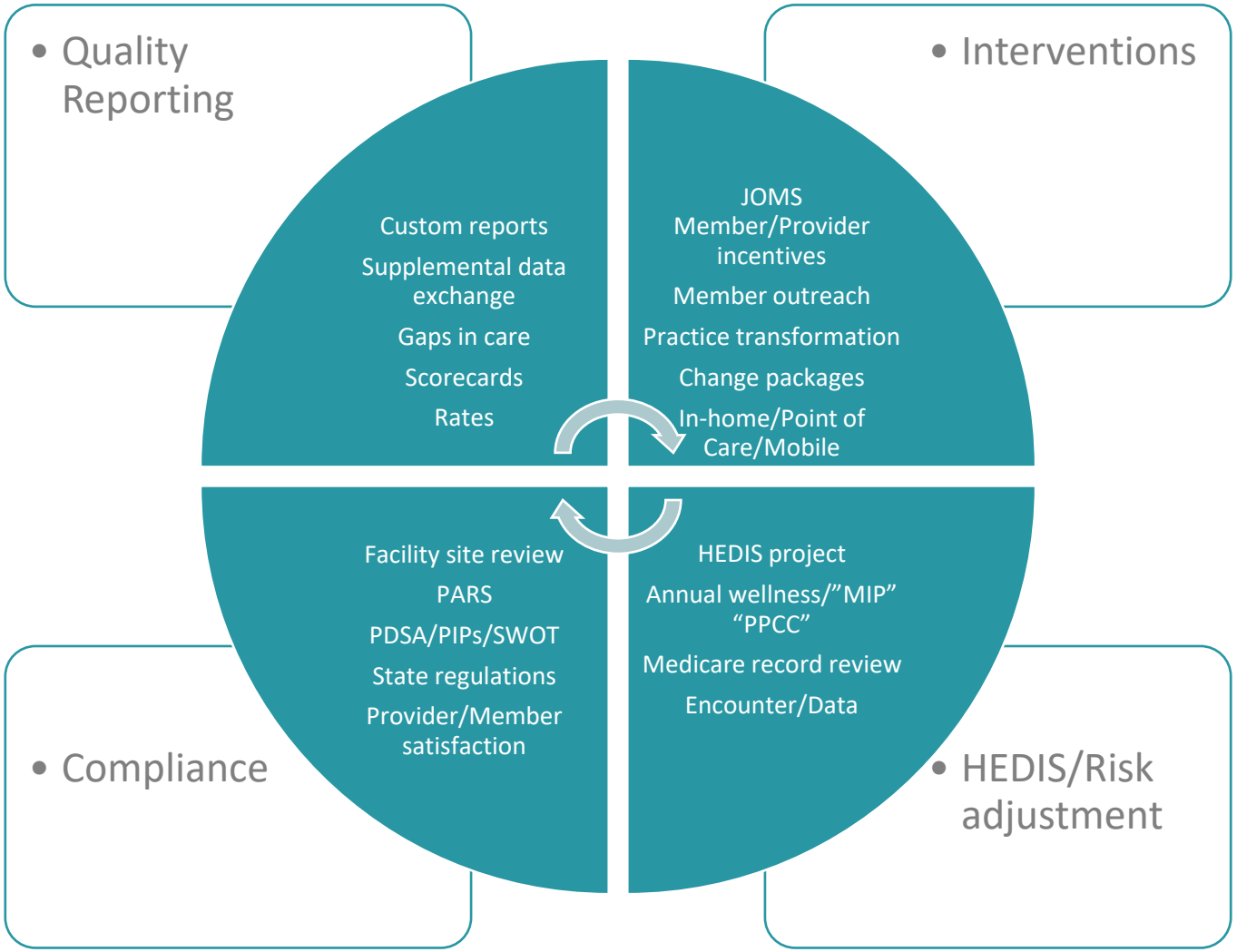
- Below is a list of the minimum items that are necessary in the maintenance of the member's medical records:
  - Each patient had a separate record.
  - Medical records are stored away from patient areas and preferably locked.
  - Medical records are available at each visit and archived records are available within 24 hours.
  - If hard copy, pages are securely attached in the medical record and records are organized by dividers or color-coded when thickness of the record dictates.
  - If electronic, all those with access have individual passwords.
  - Record keeping is monitored for quality and HIPAA compliance.
  - Storage maintenance for the determined timeline and disposal per record management processes.
  - Process for archiving medical records and implementing improvement activities.
  - Medical records are kept confidential and there is a process for release of medical records including behavioral health care records.
- Organization:
  - The medical record is legible to someone other than the writer.
  - Each patient has an individual record.
  - Chart pages are bound, clopped or attached to the file.
  - Chart sections are early recognized for retrieval of information.
  - A release document for each member authorizing Molina to release medical information for facilitation of medical care.

Medical record confidentiality

- Molina providers shall develop and implement confidentiality procedures to guard member protected health information, in accordance with HIPAA privacy standards and all other applicable federal and state regulations. This should include, and is not limited to, the following:
  - Ensure that medical information is released only in accordance with applicable federal or state Law in pursuant to court orders or subpoenas.
  - Maintain records and information in an accurate and timely manner.
  - Ensure timely access by members to the records and information that pertain to them.
  - Abide by all federal and state laws regarding confidentiality and disclosure of medical records or other health an enrollment information.
  - Medical records are protected from unauthorized access.
  - Access to computerized confidential information is restricted.
  - Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
  - Education and training for all staff on handling and maintain protected health care information.
- Additional information on medical records is available from your local Molina quality department toll free at (800) 526-8196, ext. 126137. See the compliance section of the provider manual for additional information regarding HIPAA.

Quality improvement

Quality improvement department



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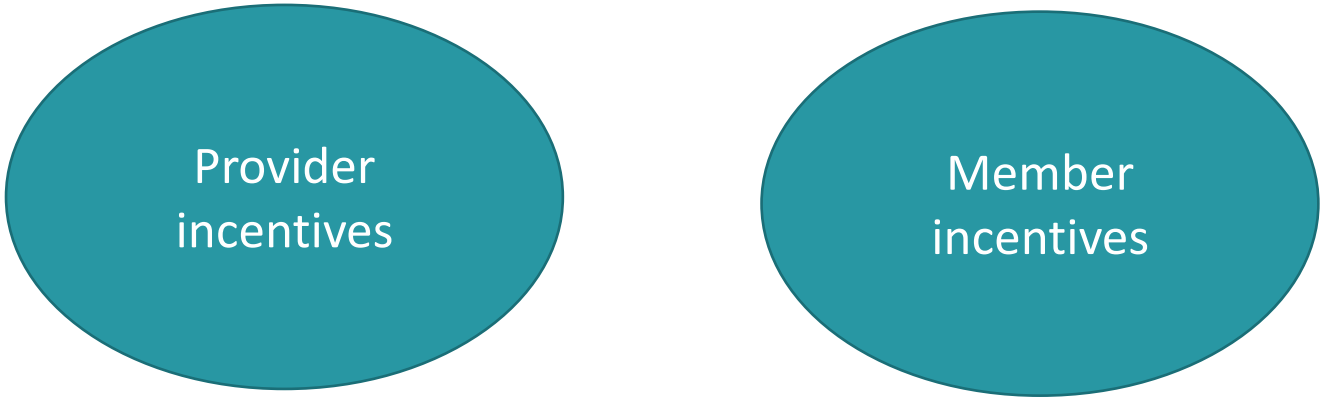
Quality improvement department

Molina's quality team monitors NCQA HEDIS measure/rates, provider incentives, member incentives, state initiatives, as well as any reporting.

We do this to collaborate with and improve our partners' HEDIS scores and patient care. We encourage and share all tools available to help patients get the best care they possibly can. If you have any questions, please reach out to your assigned practice facilitator below.



Provider and member incentives vary from county to county. Please contact your practice transformation specialist for specific information.

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Practice transformation specialists

Please reach out your county specific specialist for interventions, provider/member incentives, any provider report requests

Region	PARS, P4P, HEDIS, and Gaps in Care Questions
Imperial	• Fernanda Garate Fernanda.Garate@MolinaHealthcare.com
San Diego	• Cindy Santa Cruz Cindy.SantaCruz@MolinaHealthcare.com
Inland Empire	• Avery Slaughter Avery.Slaughter@MolinaHealthcare.com • Michelle Mora Michelle.Mora2@MolinaHealtcare.com • Rocio Chavez Rocio.Chavez1@molinaHealthcare.com • Samwendy Asiamah samwendy.asiamah@molinahealthcare.com
Los Angeles	• Rocio Chavez Rocio.Chavez1@molinaHealthcare.com • Michelle Mora Michelle.Mora2@MolinaHealthcare.com
Sacramento	• Elizabeth Hill Elizabeth.Hill@MolinaHealthcare.com

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Facility site review

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Facility site review

WHAT is a site review?

Facility site review (FSR)

Medical record review (MRR)

Physical accessibility review survey (PARS).

WHO requires a site review?

All PCP sites participating in the Medi-Cal Managed Care Program

WHY are site reviews conducted?

FSRs are conducted to ensure that all contracted PCP sites have sufficient capacity to provide appropriate primary healthcare services and can maintain patient safety standards and practices.

California Code of Regulations (22 CCR § 56230)

California Department of Health Care Services (DHCS) All Plan Letter 22-017

MHC Policies & Procedures

WHEN is a site review needed?

Initial site review is conducted during the initial credentialing process

Periodic site review is conducted at least every 3 years thereafter

MOLINA HEALTHCARE

Facility site review

Important facility and medical record review changes (7/1/22)

- Department of Health Care Services (DHCS) has updated the facility site review (FSR) and medical record review (MRR) criteria that Molina nurse reviewers use as the tools to conduct initial and periodic audits.
- The updates are aligned with local, state, and federal guidelines, as well as recommendations from national experts in prevention and evidence-based medicine, to ensure the provision of preventive services are in accordance with:
  - American Academy of Pediatrics, Bright Futures;
  - US Preventive Services Task Force, Grade A and B recommendations;
  - American College of Obstetricians and Gynecologist/Comprehensive
  - Perinatal Services Program; and
  - Advisory Committee on Immunization Practices

The Medi-Cal Managed Care Plans in California have collaborated to create FSR and MRR training videos in order to assist you in preparing for these changes. You can view the training videos here!

Fraud prevention

Ethical standards

Molina Healthcare of California ("Molina") seeks to uphold the highest ethical standards for the provision of health care benefits and services to its members and supports the efforts of federal and state authorities in their enforcement of prohibitions of fraudulent practices by providers or other entities dealing with the provision of health care services.

- **“Abuse”** means practices that are inconsistent with sound fiscal, business, or medical practices that result in an unnecessary cost to the Medicaid/Medicare programs or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid/Medicare programs. (**42 CFR 455.2** and as further defined in Welf. & Inst. Code Section 14043.1 (a).)

- **"Fraud"** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (**42 CFR 455.2** W. & I. Code Section14043.1(I).)

Examples of fraud and abuse

By a Member	By a Provider
• Using someone else's insurance card	• False coding, records, or altered claims
• Forging a prescription	• Billing for services not rendered or goods not provided
• Knowingly enrolling someone not eligible for coverage under their policy or group coverage	• Billing separately for services that should be a single service
• Providing misleading information on or omitting information from an application for health care coverage, or intentionally giving incorrect information to receive benefits	• Billing for services not medically necessary
• Altering the billed amount for services Altering the service date	• Overutilization: Medically unnecessary diagnostics, unnecessary durable medical equipment, unauthorized services, inappropriate procedure for diagnosis

Additional provider crimes:

- Knowingly and willfully solicits or receives payment of kickbacks or bribes in exchange for the referral of Medicare or Medicaid patients
- A physician knowingly and willfully referring Medicare or Medicaid patients to health care facilities in which or with which the physician has a financial relationship (The Stark Law)
- Balance billing Medi-Cal Members - asking the patient to pay the difference between the discounted fees, negotiated fees, and the provider's usual and customary fees

Reporting fraud and abuse

- You may report suspected cases of fraud and abuse to Molina's Compliance Officer.
- You have the right to have your concerns reported anonymously to Molina, the California Department of Health Services, and/or United States Office of Inspector General.
- When reporting an issue, please provide as much information as possible. The more information provided the better the chance the situation will be successfully reviewed and resolved.
- Include the following information when reporting suspected fraud or abuse:
    - Nature of complaint
    - The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, Medicaid ID number and any other identifying information
    - Molina Healthcare AlertLine: **(866) 606-3889**

Fraud, waste and abuse

You may anonymously report fraud and abuse to Molina through one of the following:

- **By phone**
  Call the Toll-Free number of the Molina Healthcare of California, Molina Healthcare AlertLine: **(866) 606-3889**
- **Website**
  www.MolinaHealthcare.alertline.com
- **Regular mail**
  - Write (**marked confidential**) to: **Compliance Officer**
    Molina Healthcare of California
    200 Oceangate, Suite 100
    Long Beach, CA 90802
- **California Department of Health Care Services, or United States Office of Inspector General by:**
  - Calling the toll-free number of the Department of Health Care Services Anti-Fraud Line: **(800) 822-6222** or sending an e-mail to: stopmedicalfraud@dhcs.ca.gov
  - Call the toll-free number of the Office of Inspector General: **(800) 447-8477**

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Questions?

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