Molina Matters

A newsletter for Molina Healthcare MSCAN and CHIP Provider Networks

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MOLINA® HEALTHCARE

Your Extended Family.

2019-2020 Flu Season

The Advisory Committee on Immunization Practices (ACIP) continues to recommend annual influenza vaccinations for everyone who is at least 6 months of age and older. It's especially important that certain people get vaccinated, either because they are at high risk of having serious flu-related complications or because they live with or care for people at high risk for developing flu-related complications. A licensed, recommended, and age-appropriate vaccine should be used. Inactivated influenza vaccines (IIVs), recombinant influenza vaccine (RIV), and live attenuated influenza vaccine (LAIV) are expected to be available for the 2019–20 season. Standard-dose, unadjuvanted, inactivated influenza vaccines will be available in quadrivalent formulations (IIV4s). High-dose (HD-IIV3) and adjuvanted (aIIV3) inactivated influenza vaccines will be available in trivalent formulations. Recombinant (RIV4) and live attenuated influenza vaccine (LAIV4) will be available in quadrivalent formulations.

Important Update:

The A viral vaccine components have been updated for the 2019-20 flu season and the B viral vaccine component remains the same from the 2018-19 flu season.

The age indication for Afluria Quadrivalent has been expanded from ≥5 years to ≥6 months. The dose volume for Afluria Quadrivalent is 0.25 mL for children aged 6 through 35 months and 0.5 mL for all persons aged ≥36 months (≥3 years).

The dose volume for Fluzone Quadrivalent for children aged 6 through 35 months, which was previously 0.25 mL, is now either 0.25 mL or 0.5 mL. The dose volume for Fluzone Quadrivalent is 0.5 mL for all persons aged ≥36 months (≥3 years).

For a complete copy of the ACIP recommendations and updates or for information on the flu vaccine options for the 2019-2020 flu season, please visit the Centers for Disease Control and Prevention at **https://www.cdc.gov/flu/professionals/vaccination/**.

Top Denials/Rejections

Rejected vs Denied Claim

Molina processes claims in an accurate and timely manner with minimal disturbances. Claim denials and rejections happen for a variety of reasons.

Rejected Claim	does not meet basic claims processing requirements.	A few examples of rejected claims include the use of an incorrect claim form, required fields are left blank or required information is printed outside the appropriate fields
Denied claim	The claim has been reviewed and was determined not to meet payment requirements.	A few examples of reasons for denied claims include an invalid modifier, a missing: provider address, date of service or NPI and corrected claims indicator or original claim number.

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Molina's highest volume of billing errors by providers:	
Member not found	Check a beneficiary's eligibility prior to submission of each claim. Providers should also periodically review the beneficiary's eligibility information.
Missing incomplete/invalid payer claim control number	Corrected or Void/Replacement claims must include the correct coding to denote if the claim is Replacement or Corrected along with the ICN/DCN (original claim ID
Paper Claim Rejections	To avoid delay claim payment, ensure the information provided on a paper claim submission is readable, legible and without white out
Invalid/missing member ID	Member ID can be submitted with or without leading zero's. When leading zeroes are added, it must only contain 5 leading zeros

Paper Claim Billing Tips

Providers must be mindful of the following items when submitting paper claims to avoid rejections, denials, or delays in processing these submissions.

- Handwritten claims are not accepted
- Black & White CMS 1500 claims are not accepted
- Copies of claim forms are not accepted
- Printouts of electronic claims are not accepted
- White-Out on claim forms is not accepted
- Please do not submit information that is typed, then crossed out and corrected
- Print should not be too dark or too light
- Check alignment of data
- Do not write or stamp in data fields
- Claim total at the end of the page indicates end of claim
- Staples in claim forms are not accepted

Non-Participating Providers

Important Notice to Non-Participating Providers

All Out-of-Network Providers (Physicians, Nurse Practitioners, Facilities, and Ancillary Providers) must obtain a Prior Authorization (PA) prior to rendering services. All Non-Participating Providers require authorization regardless of services or codes.

To join our network, please complete the Contract Request Form found on our website at **https://www.molinahealthcare.com/providers/ms/medicaid/forms/Pages/fuf.aspx** and follow the instructions given.

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After completing, a representative from our Provider Contracting Department will reach out to you regarding the enrollment and credentialing process.

For additional information, email **MHMSProviderContracting@Molinahealthcare.com**

The Prior Authorization Guide and forms are located on our website at:
https://www.molinahealthcare.com/providers/ms/medicaid/forms/Pages/fuf.aspx

Reimbursement of Non-Participating Providers

Non-Participating Providers are reimbursed at 50% of the current Mississippi Medicaid Fee-For-Service Fee Schedule for covered Non-Emergent services, if accompanied by a valid prior authorization number.

Non-Participating Providers are reimbursed at 100% of the current Mississippi Medicaid Fee-For-Service Fee Schedule for covered Emergency Services. Prior authorization is not required for covered Emergency Services.

Reimbursement will be limited to a period for the treatment of an Emergency Medical Condition, including Medically Necessary services rendered to the Member until such time as he or she may be safely transported to a network Provider service location. From that time forward, the applicable non-participating provider rate will apply.

Members experiencing an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the patient.

Molina Healthcare's Special Investigation Unit Partnering with You to Prevent Fraud, Waste and Abuse

The National Healthcare Anti-Fraud Association estimates that least three percent of the nation's health care costs, amounting to tens of billions of dollars, is lost to fraud, waste, and abuse. That's money that would otherwise cover legitimate care and services for the neediest in our communities. To address the issue, federal and state governments have passed a number of laws to improve overall program integrity, including required audits of medical records against billing practices. Molina Healthcare, like others in our industry, must comply with these laws and proactively ensure that government funds are used appropriately. Molina's Special Investigation Unit (SIU) aims to safeguard Medicare and Medicaid, along with Marketplace funds.

You and the SIU

The SIU analyzes providers by using software that identifies questionable coding and/or billing patterns, and to determine compliance with the terms of the Provider Agreement, including for the purpose of investigating potential fraud, waste and abuse along with concerns involving medical necessity. As a result, providers may receive a notice from the SIU if they have been identified as having outliers that require additional review or by random selection. If your practice receives a notice from the SIU, please cooperate with the notice and any

instructions, such as providing requested medical records and other supporting documentation. Should you have questions, please contact your Provider Services Representative.

"Molina Healthcare appreciates the partnership it has with providers in caring for the medical needs of our members," explains Scott Campbell, the Molina Associate Vice President who oversees the SIU operations. "Together, we share a responsibility to be prudent stewards of government funds. It's a responsibility that we all should take seriously because it plays an important role in protecting programs like Medicare and Medicaid from fraudulent activity."

Molina appreciates your support and understanding of the SIU's important work, and we hope to minimize any inconvenience the SIU audit might cause you and/or your practice.

To report potential fraud, waste, and abuse, you may contact the Molina AlertLine toll-free at (866) 606-3889 24 hours per day, 7 days per week. In addition, you may use the service's website to make a report at any time at.

Molina Care Management Updates

Molina Healthcare of Mississippi partners closely with our provider network to care for our members with chronic and end-stage kidney disease. Clinical best practice demonstrates that timely referral to a nephrologist and early dialysis preparation are key to achieving quality of care outcomes. Additionally, as recommended by the National Kidney Foundation, for individuals for whom Peritoneal Dialysis is appropriate, members may experience significant health benefits compared to traditional hemodialysis. For additional questions, please reach out to **MHMS_CM_Referrals@MolinaHealthCare.Com**

Refer CKD patients (GFR < 60) to a nephrologist in a timely manner

- Impaired kidney function and proteinuria increase the risk of cardiovascular disease 2 to 4 times, even after adjusting for traditional cardiovascular risk factors! (Gansevoort RT et al. Lancet. 2013 Jul;382(9889):339-52)
- Early appointments (beginning 6 months or more before dialysis) and frequent care (at least one nephrology visit every 3 months) are associated with 10% lower risk for major adverse cardiovascular events (acute MI, acute heart failure, acute stroke, or sudden death). (Yang J, et al. Am J Kidney Dis. 2017)

Peritoneal Dialysis Preferred

- Most nephrologists would choose peritoneal dialysis (PD) over hemodialysis (HD) for themselves! "96% of nephrologists surveyed recently would choose PD over HD if they had to go on dialysis themselves" (Merighi, JR et al. Hemodial Int. 2012; 16: 242-251)
- Residual kidney function is maintained longer with PD than HD: In a prospective study, PD patients had an 8.1% decline in GFR per month compared to 10.7% decline in GFR per month for HD patients (Jansen M, et al. Kidney Int 2002; 62: 1046-53)
- PD reduces vascular access interventions. In a prospective observational study in Canada between 2007 and 2010, mean number of access interventions was significantly less in PD than HD patients (p =0.005) (Oliver MJ, et al. Nephrol Diol Transplant 2012; 27:810-816)
- Absolute PD Contraindications are few: bowel cancer, diverticulitis, colostomy/ileostomy, ischemic bowel, excessive abdominal scarring from prior abdominal surgeries.

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Refer patients early to vascular surgeon for PD catheter or fistula/graft to avoid central venous catheter

- AV fistulas or AV grafts result in much better outcomes. Hemodialysis catheter use needs to be avoided or minimized to avoid complications, especially central vein stenosis, which substantially reduces the success of future AV fistulas. In a retrospective review, the cumulative risk of any catheter-related complications was 30 percent at one year and 38 percent at two years. The one-year risk of bacteremia was 9 percent. Central vein stenosis or thrombosis occurred in 1.5 percent of patients (Poinen K et al. Am J Kidney Dis. 2019;73(4):467)
- To minimize catheter use, all pre-dialysis patients with an expected start of hemodialysis within one year and patients who have initiated hemodialysis urgently with a catheter should be referred to a vascular surgeon to determine eligibility for AV access or PD catheter. Central venous catheters should be reserved only for those with limited life expectancy (eg, metastatic cancer) or patients with a very short expected duration of hemodialysis (eg, pending live-related transplant)

Transplant evaluation

- Patients who are interested in transplantation and who have no known contraindications should be referred to a transplantation program before they even start dialysis, when the estimated glomerular filtration rate (eGFR) is <30 GM mL/min/1.73 m^2. (Bunnapradist S, Danovitch Am J Kidney Dis. 2007;50(5):890)
- Absolute contraindications for transplant include: active substance abuse, active malignancy, active infection, reversible renal failure, uncontrolled psychiatric disease, documented active and ongoing treatment nonadherence, or a significantly shortened life expectancy.

Patient Driven Payment Model

Effective October 1, 2019 the new Patient Driven Payment Model (PDPM) was implemented by the Centers for Medicare and Medicaid Services (CMS). CMS to replace the Resource Utilization Group (RUG), Version IV for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS).

Molina Healthcare is following CMS Medicare methodology for the PDPM implementation, and has posted a **Frequently Asked Questions (FAQ)** resource document under the "communications" header on our Medicare page of the Molinahealthcare.com website.

Molina providers reimbursed under the Medicare SNF PPS are subject to the PDPM payment transition starting with dates of service on/after October 1, 2019. The payment transition will apply to all lines of business that are contracted/required to pay Medicare allowable rates.

In order to prevent payment disruption, action is required to modify claim billing practices. There is no transition period between RUG-IV and PDPM. RUG-IV billing ends September 30, 2019. PDPM billing begins October 1, 2019.

CMS has released resources to help you prepare on the PDPM webpage, including fact sheets, FAQs, and training

materials. Please visit the CMS website at: www.cms.gov and under the "Medicare" tab find the "Medicare Fee-for-Service Payment" section, then select "Skilled Nursing Facility PPS.

Balance Billing

Providers contracted with Molina cannot bill Molina Member for any covered benefits. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Molina Member be liable to the Provider for any sums owed by Molina to the Provider. Balance billing a Molina Member for services covered by Molina is prohibited. This includes:

- Holding the Molina D-SNP Members liable for Medicare Part A and B cost sharing
- Requiring Molina Members to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees
- Charging Molina Members fees for covered services beyond copayments, deductibles or coinsurance

CGRP Inhibitors for Preventative Migraine Treatment

Three new medications gained FDA approval for the prevention of migraines in adults. These medications are humanized monoclonal antibodies that bind to the calcitonin gene-related peptide (CGRP) ligand and blocks its binding to the receptor. A brief overview of each medication is discussed below.

The first CGRP Inhibitor, approved on May 17, 2018, is called Aimovig (erenumab-aooe). Aimovig is given as a 70 mg/mL monthly subcutaneous injection, which may be increased to 140 mg/mL monthly. The efficacy of Aimovig was evaluated in three randomized, double-blind, placebo-controlled studies, with two studies including patients with episodic migraines and one study including patients with chronic migraines. In all three studies, Aimovig treatment demonstrated statistically significant improvements for mean monthly migraine days and change from baseline in monthly migraine days by the third month of treatment.

The second CGRP Inhibitor, approved on September 14, 2018, is called Ajovy (fremanezumab—vfrm). Ajovy is dosed as a single 225 mg/1.5 mL subcutaneous injection monthly or 675 mg/1.5 mL, administered as three consecutive 225 mg/1.5 mL injections, every 3 months. The efficacy of Ajovy was evaluated in two multicenter, randomized, 3-month, double-blind, placebo-controlled studies in which one study included patients with episodic migraines and the other included patients with a history of chronic migraines. Both studies demonstrated a statistically significant decrease in monthly average number of migraine days during the 3-month period from baseline.

The third CGRP Inhibitor, approved on September 27, 2018, is called Emgality (galcanezumab-gnlm). Emgality dosing for migraine prevention requires a loading dose of 240 mg/mL, administered as two consecutive 120 mg/mL subcutaneous injections, followed by monthly doses of 120 mg/ml. The efficacy of Emgality was evaluated

in three multicenter, randomized, double-blind, placebo-controlled studies, with one 3-month study including patients with chronic migraines and two 6-month studies including patients with episodic migraines. In each study, Emgality showed significant reductions in the mean number of monthly migraine headaches from baseline over the 3- and 6-month periods, respectively.

A common adverse effect for the three medications was injection site reaction. Additionally, Aimovig also reports constipation as a common adverse effect. There is no established data for the use of these medications in special populations, including in pregnancy, breast-feeding, pediatrics and geriatrics patients.

Molina Healthcare, Inc National P&T approved CGRP antagonist prior authorization criteria during the first quarter of 2019.

References:

Aimovig (erenumab-aooe) [prescribing information]. Thousand Oaks, CA: Amgen Inc; May 2018.
Ajovy [package insert]. North Wales, PA: Teva Pharmaceuticals USA, Inc: September 2018.
Emgality [package insert]. Indianapolis, IN: Eli Lilly and Company: September 2018.

Model Of Care

2019 Model of Care Training is Happening Now!

CMS requires that Contracted Providers directly or indirectly facilitating or providing Medicare Part C or D benefits for Molina SNP Members complete Model of Care training. This quick training will describe how Molina Healthcare and providers work together to successfully deliver coordinated care and case management to members with both Medicare and Medicaid.

In order to ensure compliance with CMS Regulatory Requirements, receipt of your completed Attestation Form is due to Molina Healthcare by <<date>>. If you have any additional questions, please contact your local Molina Healthcare Provider Services Representative.

Provider Portal Corner

If you're the Primary Admin for your account, you can invite additional users and manage existing users' roles to help you with your day to day activities. We highly recommend that you promote at least one other user to Admin to support your responsibilities.

It's as easy as 1-2-3 to promote a user to an Admin:

1. Go to Manage Users screen
2. Select the User ID you want to Promote
3. Select Promote as Admin button

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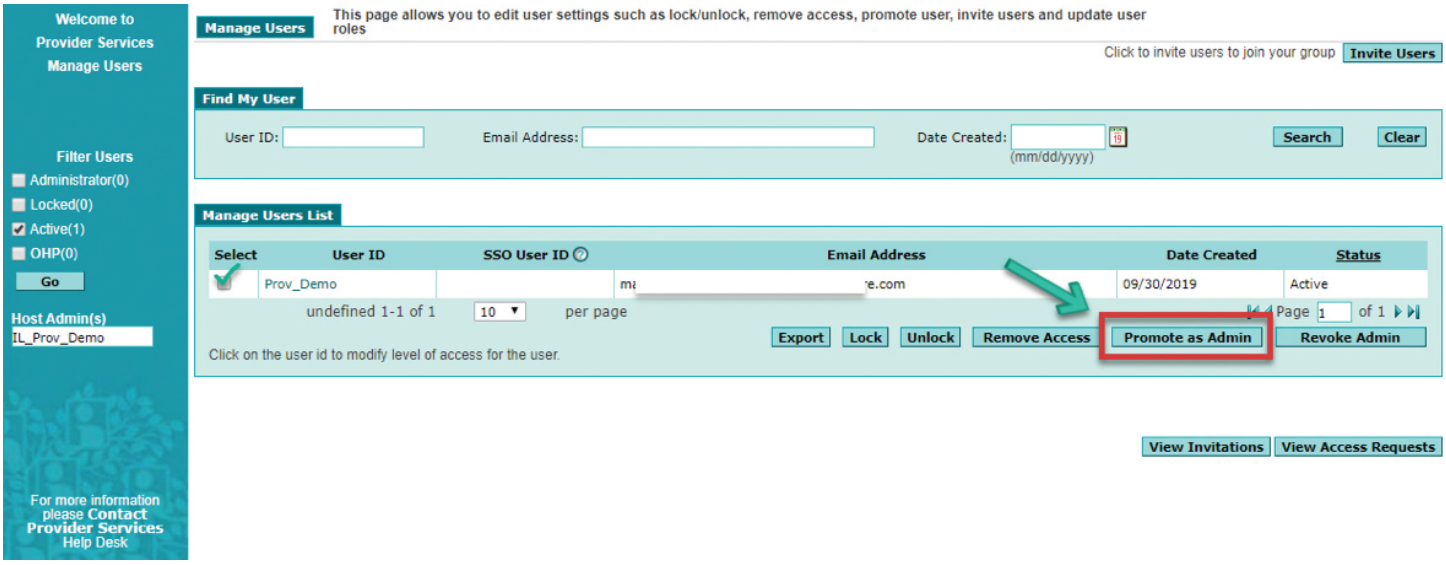

And voila! The user's status will change to "Admin/Active."

This simple step can assist you in delegating responsibilities and ensuring you always have backup support.

Submitting Electronic Data Interchange (EDI) Claims

Look at all the benefits to using EDI:

- Electronic Claims Submission ensure HIPAA compliance
- Electronic Claims Submission helps to reduce operational costs associated with paper claims (printing, postage, etc.)
- Electronic Claims Submission increases accuracy of data and efficient information delivery
- Electronic Claims Submission reduces claims delays since errors can be corrected and resubmitted electronically!
- Electronic Claims Submission eliminates mailing time and claims reach Molina faster!

EDI Claims Submission

The easiest way to submit EDI claims to Molina Healthcare is through a Clearinghouse. You may submit the EDI through your own Clearinghouse or use Molina's contracted Clearinghouse. If you do not have a Clearinghouse, Molina offers additional electronic claims submissions options. Log onto Molina's Provider Services Web Portal https://provider.molinahealthcare.com for additional information about the claims submission options, available to you.

FAQ'S

- Can I submit COB claims electronically?
  - Yes, Molina and our connected Clearinghouses fully support electronic COB.
- Do I need to submit a certain volume of claims to send EDI?
  - No, any number of claims via EDI saves both time and money.

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- Which Clearinghouses are currently available to submit EDI claims to Molina?
  - Molina Healthcare uses ClaimsNet as our channel partner for EDI claims. You may use the Clearinghouse of your choice. ClaimsNet partners with hundreds of other Clearinghouses.
- What claims transactions are currently accepted for EDI transmission?
  - 837P (Professional claims), 837I (Institutional claims).
- What if I still have questions?
  - More information is available at www.molinahealthcare.com under the EDI tab. You may also call or email us using the contact information below.

Submitting Electronic Claims

1-866-409-2935
EDI.Claims@MolinaHealthcare.com
Molina Healthcare of Mississippi Payer ID: **7 7 0 1 0**

Electronic Fund Transfer (EFT)

Molina has partnered with our payment vendor, ProviderNet, for Electronic Funds Transfer and Electronic Remittance Advice. Access to the ProviderNet portal is FREE to our participating providers and we encourage you to register after receiving your first check from Molina.

New ProviderNet User Registration:
1. Go to https://providernet.adminisource.com
2. Click "Register"
3. Accept the Terms
4. Verify your information
   a. Select Molina Healthcare from Payers list
   b. Enter your primary NPI
   c. Enter your primary Tax ID
   d. Enter recent claim and/or check number associated with this Tax ID and Molina Healthcare
5. Enter your User Account Information
   a. Use your email address as user name
   b. Strong passwords are enforced (8 or more characters consisting of letters/numbers)
6. Verify: contact information; bank account information; payment address
   a. Note: Any changes to payment address may interrupt the EFT process.
   b. Add any additional payment addresses, accounts, and Tax IDs once you have logged in.

If you are associated with a Clearinghouse:
1. Go to "Connectivity" and click the "Clearinghouses" tab
2. Select the Tax ID for which this clearinghouse applies
3. Select a Clearinghouse (if applicable, enter your Trading Partner ID)
4. Select the File Types you would like to send to this clearinghouse and click "Save"

If you are a registered ProviderNet user:
1. Log in to ProviderNet and click "Provider Info"
2. Click "Add Payer" and select Molina Healthcare from the Payers list
3. Enter recent check number associated with your primary Tax ID and Molina Healthcare

BENEFITS
- Administrative rights to sign-up/manage your own EFT Account
- Ability to associate new providers within your organization to receive EFT/835s
- View/print/save PDF versions of your Explanation of Payment (EOP)
- Historical EOP search by various methods (i.e. Claim Number, Member Name)
- Ability to route files to your ftp and/or associated Clearinghouse

If a provider has questions regarding the actual registration process, they can contact ProviderNet at: (877) 389-1160 or email: wco.provider.registration@changehealthcare.com.

Note: Providers please ensure you are registered for EFT for all participating Lines of Business.

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Are You Culturally Competent?

Cultural and linguistic competency is the ability to provide respectful and responsive care to members with diverse values, beliefs and behaviors, including tailoring health care delivery to meet members' social, cultural and linguistic needs. The National CLAS (Culturally and Linguistically Appropriate Services) Standards, developed by the Health and Human Services Office of Minority Health, aim to improve health care quality and advance health equity by establishing a collective set of mandates and guidelines that inform, guide and facilitate culturally and linguistically appropriate services.

Communicating Across Cultures

Clear communication is the foundation of culturally and linguistically competent care.

Guiding the conversation

- Initial greetings can set the tone for an interaction. If the patient's preference is not clear, ask how they would like to be addressed (i.e. Mr. Jones, Michael, and Ms. Gonzalez).
- Ask open-ended questions whenever possible.
- Some individuals can tell you more about themselves through story telling than by answering direct questions.
- Inquire about preferred language and preferred method of communication (i.e. written, spoken, graphics, sign language, assistive listening devices, etc.).
- Consider treatment plans with respect to the patient's culture-based beliefs about health.
- Ask about any complimentary or alternative medicine possibly used by the patient.

Assisting patients whose first language is not English

- Speak slowly and try not to raise your voice
- Use simple words and avoid jargon
- Do not use acronyms, idioms and avoid technical language if possible. (i.e. shot vs. injection)
- Please articulate words
- Give information in small chunks and short sentences
- Repeat important information and have the patient repeat information back to you
- Inform the interpreter of any specific patient needs
- Hold a brief introductory discussion
- Reassure the patient about confidentiality
- Allow enough time for the interpreted sessions
- Avoid interrupting during interpretation
- Speak in the first person
- Talk to the patient directly, rather than addressing the interpreter

Please remember that it is never permissible to ask a minor, family member or friend to interpret.

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Molina's language access services

Molina strives to ensure good communication with members by providing language access services. Providing language access services is a legal requirement for health care systems that are recipients of federal funds; a member cannot be refused services due to language barriers. Language access services ensure mutual understanding of illness and treatment, increase patient satisfaction and improve the quality of health care for Limited English proficiency patients.

Molina provides the following services to members at no cost, when needed:

- Written material in other formats (i.e. large print, audio, accessible electronic formats, Braille)
- Written material translated into languages other than English
- Oral and Sign Language Interpreter Services
- Relay Service (711)
- 24 Hour Nurse Advice Line
- Bilingual/Bicultural Staff

Also, Molina's materials are always written simply in plain language and at required reading levels. For additional information on Molina's language access services or cultural competency resources, contact Provider Services or visit **www.MolinaHealthcare.com**.

Sources:

U.S. Department of Health & Human Services: Office of Minority Health. Health Research & Educational Trust, 2013. Industry Collaboration Effort, Better Communication, Better Care: Provider Tools to Care for Diverse Populations. Industry Collaboration Effort, Cultural and Linguistic Services, 2017.

Pharmacy Update - Lorbrena

Lorbrena (lorlatinib) is a third-generation tyrosine kinase ALK inhibitor made by Pfizer. It was given accelerated approval by the FDA for the treatment of anaplastic lymphoma kinase (ALK)-positive, metastatic, non-small cell lung cancer (NSCLC) in patients whose disease has progressed on specified therapies (other ALK inhibitors) on November 2, 2018.

Lung cancer is the second most common cancer in the U.S. and the leading cause of cancer deaths. NSCLC is the most common type of lung cancer. Adjuvant therapies typically involve regimens with cisplatin or carboplatin. In metastatic cases that are ALK gene rearrangement positive, alectinib, crizotinib, ceritinib, or brigatinib may be used.

In a non-randomized, multi-center study of a subgroup of 215 patients with ALK positive NSCLC previously treated with one or more ALK inhibitors, the overall response rate with lorlatinib treatment was 48%. The estimated median response rate was 12.5 months. Common adverse reactions were edema, peripheral neuropathy, cognitive effects, dyspnea, fatigue, weight gain, arthralgia, mood effects, and diarrhea, occurring in greater than or equal to 20% of patients.

Lorlatinib is contraindicated in patients taking strong CYP3A4 inducers. The recommended dose is 100 mg orally daily until disease progression or unacceptable toxicity.

References:

1. Food and Drug Administration. FDA approves lorlatinib for second- or third-line treatment of ALK-positive

metastatic NSCLC. https://www.fda.gov/Drugs/InformationOnDrugs/ApprovedDrugs/ucm625027.htm. Accessed February 11, 2019.
2. NCCN Guidelines Version 4.2018: Non-Small Cell Lung Cancer
3. Lorlatinib. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Hudson, OH. Available at: http://online.lexi.com Accessed February 11, 2019.

Model of Care

Coming soon: 2019 Molina Health Model of Care Provider Training

The Centers for Medicare & Medicaid Services (CMS) requires all contracted medical Providers and staff receive basic training about the Special Needs Plans (SNPs) Model of Care. The SNPs Model of Care is the plan for delivering coordinated care and care management to special needs Members. SNPs are responsible for conducting their own MOC training, which means you may be asked to complete multiple trainings by different health plans. CMS requires us to show evidence of the availability of MOC training materials communicated to Providers.

The completion date for this year's training is <<October 1, 2019>>.

If you have any additional questions, please contact your local Molina Healthcare Provider Services Representative.

Is Your Authorization Request Urgent?

CMS defines expedited/urgent authorization requests as - "applying the standard time for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function"

When submitting urgent/expedited prior authorization requests, keep the following items in mind to ensure the request is processed without delay:

- Urgent/Expedited service request designation should only be used if the treatment is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition will be handled as routine/ non-urgent.
- Priority is based on turn-around time and then order of receipt.
- For a smoother, faster process please remember to include all the supporting clinical/documents.

DirectAssure

We are now collaborating with DirectAssure to help maintain a more accurate and timelier provider directory. Working in concert with CAQH ProView®, which is accessed by 1.4 million providers to self-report and regularly attest to their professional and practice information, DirectAssure enables providers to update their directory information once and share it with all participating health plans they authorized to receive that data.

We encourage all providers to sign up for CAQH ProView® in order to utilize DirectAssure as a tool to easily update and distribute provider directory data to Molina Healthcare. DirectAssure reduces the burden on healthcare providers and health plans alike, eliminating redundant outreach and increasing directory accuracy.

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How DirectAssure Works:

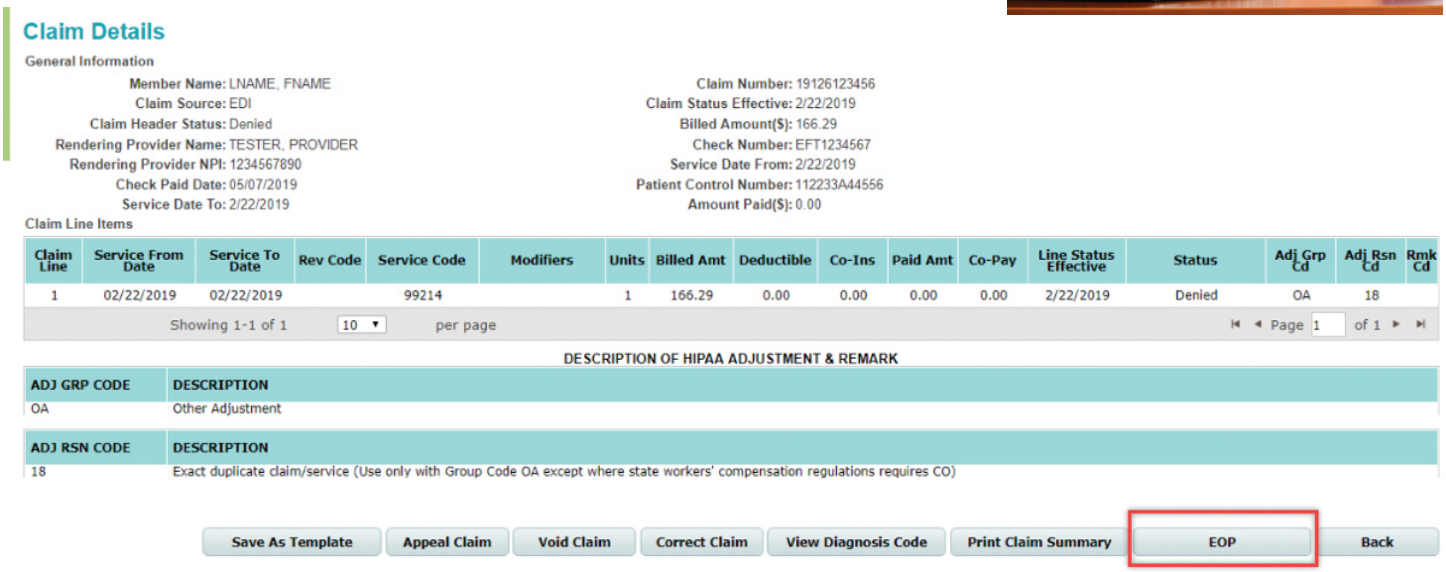
- DirectAssure emails reminders, on at least a quarterly basis, to select providers on behalf of participating health plans to review their directory information.
- Providers log in to CAQH ProView®, review a specific dataset in a Provider Directory Snapshot, make any necessary updates and then confirm that the directory information can be published.
- The confirmation is time stamped, and a snapshot of information is taken for audit purposes.
- This directory data includes provider location, contact information, specialty, medical group, institutional affiliation and whether they are accepting new patients.

To register, please visit **https://www.caqh.org/**. For more information about DirectAssure, visit **https://www.caqh.org/solutions/directassure**.

If you have any questions, please contact your Provider Services Representative.

Provider Portal Corner

We have enhanced the Provider Portal to include access to the PDF images of the Explination of Payment (EOP) documents that come with your Molina claims payments. EOPs can be accessed for claims that have a paid/denied status. Navigation to the EOP is done through the Claims Inquiry module of the Portal. Search for the desired claim, and from the Claims Details page, select the "EOP" button. This will open the PDF of the EOP.



Claim Details

General Information

Member Name: LNAME, FNAME
Claim Source: EDI
Claim Header Status: Denied
Rendering Provider Name: TESTER, PROVIDER
Rendering Provider NPI: 1234567890
Check Paid Date: 05/07/2019
Service Date To: 2/22/2019

Claim Number: 19126123456
Claim Status Effective: 2/22/2019
Billed Amount($): 166.29
Check Number: EFT1234567
Service Date From: 2/22/2019
Patient Control Number: 112233A44556
Amount Paid($): 0.00

Claim Line Items

Claim Line	Service From Date	Service To Date	Rev Code	Service Code	Modifiers	Units	Billed Amt	Deductible	Co-Ins	Paid Amt	Co-Pay	Line Status Effective	Status	Adj Grp Cd	Adj Rsn Cd	Rmk Cd
1	02/22/2019	02/22/2019		99214		1	166.29	0.00	0.00	0.00	0.00	2/22/2019	Denied	OA	18	

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DESCRIPTION OF HIPAA ADJUSTMENT & REMARK

ADJ GRP CODE	DESCRIPTION
OA	Other Adjustment

ADJ RSN CODE	DESCRIPTION
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)

Save As Template | Appeal Claim | Void Claim | Correct Claim | View Diagnosis Code | Print Claim Summary | EOP | Back

Molina Healthcare Contact Information

Mississippi

The following is a list of contact information to assist you in making the appropriate contact with the service departments of Molina Healthcare of Mississippi (MHMS).

Department	Contact Information
24 Hour Advice Line This telephone-based nurse advice line is available to all Molina Healthcare members. Members may call anytime they are experiencing symptoms or need healthcare information. Registered nurses are available 24 hours a day, seven days a week to assess symptoms and help make good healthcare decisions.	• **Phone:** (844) 794-3638, TTY/TDD 711
Appeals **Pre-Service Appeals** For providers seeking to appeal a denied Prior Authorization (PA) on behalf of a member only, fax Member Appeals. **Post-Service Appeals** For providers seeking to appeal a denied claim only, fax Provider Claim Disputes/Appeals.	**Pre-Service Appeals** Member Appeals Fax: (844) 808-2407 **Post-Service Appeals** Provider Claims Disputes/Appeals Fax: (844) 808-2409
Authorizations	• **Prior Authorizations** Phone: (844) 826-4335 Inpatient Requests Fax: (844) 207-1622 All Non-Inpatient Fax: (844) 207-1620 • **Radiology Authorizations** Phone: (855) 714-2415 Fax: (877) 731-7218 • **Transplant Authorizations** Phone: (855) 714-2415 Fax: (877) 813-1206 • **NICU Authorizations** Phone: (855) 714-2415 Fax: (877) 731-7220 • **WebPortal** www.MolinaHealthcare.com/provider

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Department	Contact Information
Avesis (Dental and Hearing)	• **Phone:** (833) 282-2419 www.avesis.com
Behavioral Health Molina Healthcare of Mississippi, Inc. manages all components of our covered services for behavioral health.	• **Phone:** (844) 826-4335 • **Inpatient Fax:** (844) 207-1622 • **All Non-Inpatient Fax:** (844) 206-4006 • **Email:** MSBHProviderServices@MolinaHealthcare.com
Claims (Non-Pharmacy) The Claims Department is located at our corporate office in Long Beac h, CA. All hard copy (CMS-1500, UB-04) claims must be submitted by mail to the address indicated. Note: Electronically filed claims must use Payor ID number – 77010.	• **Phone:** (844) 826-4335 provider. MolinaHealthcare.com • **Address:** Molina Healthcare of Mississippi, Inc. PO Box 22618 Long B each, CA 90801
Claims Recovery/Refund Department The Claims Recovery Department manages recovery for overpayment and incorrect payment of claims. Refunds and supporting documentation must be submitted to the address indicated.	• **Phone:** (866) 642-8999, option 3-2 • **Fax:** (844) 891-2863 • **Address:** Molina Healthcare of Mississippi, Inc. PO BOX 603696 Charlotte, NC 28260 - 3696
Contracting & Credentialing The Credentialing Department verifies all information on the Practitioner Application prior to contracting and re-verifies this information every three years. The information is then presented to the Professional Review Committee to evaluate a provider's qualifications to participate in the Molina Healthcare network.	• **Phone:** (844) 826-4335 • **Fax:** (844) 861-1577 • Email: MHMSProviderContracting@MolinaHealthcare.com • **Address:** 188 E. Capitol Street, Suite 700 Jackson, MS 39201
Eligibility	• **Phone:** (844) 826-4335 • **WebPortal:** provider.MolinaHealthcare.com
Fraud and Abuse Prevention	• **Phone:** (866) 606-3889 www.MolinaHealthcare.alertline.com

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Department	Contact Information
Health Education/Management The Health Education and Health Management Department provides education and health information to Molina Healthcare members and facilitates provider access to the programs and services.	• **Health Education** Phone: (866) 472-9483 • **Weight Management** Phone: (866) 472-9483 • **Smoking Cessation** Phone: (866) 472-9483 • **Health Mgmt & Maternity** Phone: (866) 891-2320 • **Pregnancy Notification** Fax: (866) 206-0435 • **Healthcare Services** Phone: (866) 826 4335 • **Case Management** Phone: (866) 826 4335
March Vision	• **Phone:** (844) 606-2724
Member Services The Member Services Department handles all telephone and written inquiries regarding member claims, benefits, eligibility/identification, selecting or changing Primary Care Providers (PCPs), and member complaints.	• **Phone:** (844) 809-8438, TTY/TDD 711 • **Hours:** 7:30 am - 8:00 pm M – F and the second weekend of every month from 8:00 am - 5:00 pm • **Address:** Molina Healthcare of Mississippi, Inc. 188 E. Capitol Street, Suite 700 Jackson, MS 39201
Pharmacy Prescription drugs are covered by Molina Healthcare, via our pharmacy vendor, CVS Caremark. A list of in-network pharmacies is available on our website, or by contacting Molina Healthcare.	• **Phone:** (844) 826-4335 • **Fax:** (844) 312-6371

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Department	Contact Information
Provider Services The Provider Services Department provides education and training to the provider community. This team also handles telephone and written inquiries from providers for inquiries such as demographic changes, claims, credentialing, and web portal assistance. The department has Provider Services Representatives who serve all providers in Molina Healthcare of Mississippi's provider network. Providers may contact the Provider Services Contact Center to locate the Provider Services Representative that serves their local area.	• **Phone:** (844) 826-4335 • **Fax:** (844) 303-5188 • **Address:** Molina Healthcare of Mississippi, Inc. 188 E. Capitol Street, Suite 700 Jackson, MS 39201
Southeastrans **(Nonemergency Transportation)**	• **Phone:** (855) 391-2355 option 1 – Customer Service option 2 – Where's My Ride option 9 – Spanish • **Hours of Operation:** 7:30 am – 5:30 pm CST Monday – Friday • **Urgent Care Trips:** Available 24/7 www.southeastrans.com/members/molina-healthcare-mississippi
Utilization Management (Authorizations & Inpatient Census) The Healthcare Services (formerly UM) Department conducts concurrent review on inpatient cases and processes Prior Authorization requests. The Healthcare Services (HCS) Department also performs Case Management for members who will benefit from Case Management services.	• **Prior Authorizations** Phone: (844) 826-4335 Inpatient Requests Fax: (844) 207-1622 All Non-Inpatient Fax: (844) 207-1620 • **Radiology Authorizations** Phone: (855) 714-2415 Fax: (877) 731-7218 • **Transplant Authorizations** Phone: (855) 714-2415 Fax: (877) 813-1206 • **NICU Authorizations** Phone: (855) 714-2415 Fax: (877) 731-7220 • **Address** 188 E. Capitol Street, Suite 700 Jackson, MS 39201

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