Molina Healthcare of Virginia Behavioral Health Provider Orientation

2022 | Presented by: Provider Services

MOLINA HEALTHCARE

Agenda

1. Introduction to Molina Healthcare
2. Member Rights and Responsibilities
3. Behavioral Health Provider Roles & Responsibilities
4. Provider Tools & Resources
5. Healthcare Services
6. Quality
7. Claims
8. Compliance
9. Questions

Introduction to Molina Healthcare

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MOLINA HEALTHCARE

About Molina Healthcare

Our Vision

We will distinguish ourselves as the low cost, most effective and reliable health plan delivering government-sponsored health care.

Our Mission

We improve the health and lives of our members by delivering high-quality health care.

About Molina Healthcare

These are our Values:

Integrity Always
Quality of being honest, whole, and undivided.

Absolute Accountability
Complete the tasks we are assigned, to perform the duties required by our jobs, and to always be present.

Supportive Teamwork
Having commitment and trust with one another and adaptable to changing conditions.

Honest & Open Communication
The way relationships are built and a vital ingredient to any successful organization.

Member & Community Focused
We honor and bring together people whose leadership, volunteerism, and public advocacy embody the spirit of service and community to our members.

The Molina Story

In 1980, the late Dr. C. David Molina, founded Molina Healthcare with a single clinic and a commitment to provide quality healthcare to those most in need and least able to afford it. This commitment to providing access to quality care continues to be our mission today, just as it has been for the last 41 years.

The Molina Family of Health Plans

- Molina Healthcare of California
- Molina Healthcare of Utah
- Molina Healthcare of Michigan
- Molina Healthcare of Washington
- Molina Healthcare of New Mexico
- Molina Healthcare of Texas
- Molina Healthcare of Ohio
- Molina Healthcare of Florida
- Molina Healthcare of Wisconsin
- Molina Healthcare of Illinois
- Molina Healthcare of South Carolina
- Molina Healthcare of New York
- Molina Healthcare of Mississippi
- Passport Health Plan by Molina Healthcare (KY)
- Molina Healthcare – Molina Complete Care (AZ)
- Molina Healthcare – Molina Complete Care (VA)
- Senior Whole Health by Molina Healthcare (NY)
- Senior Whole Health by Molina Healthcare (MA)

LEAN ON MOLINA

MOLINA'S MEMBERSHIP COVERAGE

We serve members in the states of Arizona, California, Florida, Idaho, Illinois, Kentucky, Massachusetts, Michigan, Mississippi, New Mexico, New York, Ohio, South Carolina, Texas, Utah, Virginia, Washington, and Wisconsin.

Medicaid
3,624,220 Members

Marketplace
601,697 Members

Medicare
110,420 Members

- Dual Eligible Special Needs Plan (D-SNP)
- Duals Demonstration
- Medicare Advantage

> **"They care about their clients, and I'm so thankful for them. It's the support system I need to get to the point that I can take care of me. I can call any one of these people at Molina, and they remind me where I was, and where I've come to, and where I'm going."**
>
> **Diane, member**

Recognized for Quality, Innovation, and Success

- Molina Healthcare plans have been ranked among America's top Medicaid plans by U.S. News & World Report
- FORTUNE 500 Company by Fortune Magazine
- Business Ethics magazine 100 Best Corporate Citizens
- Alfred P. Sloan Award for Business Excellence in Workplace Flexibility in 2011
- 11 of our 13 plans have earned the Multicultural Health Care Distinction from NCQA
- Molina Healthcare is a leader in quality with the majority of its health plans accredited and rated by the National Committee for Quality Assurance (NCQA).

MOLINA HEALTHCARE

Strategic Priorities – Molina Healthcare of Virginia

In all that we do, we will stay true to our mission, vision and values by delivering on four strategic priorities:

1. Maximizing value
2. Facilitating effective care management
3. Improving administrative efficiency, eliminating obstacles
4. Breaking down barriers to accessing care

Achieving our Goals

Creating a Collaborative Approach – Excellence begins with understanding:

- ❑ Establish a relationship
- ❑ Successful implementation
  - System load (benefits, contract terms, demographics)
  - FFS and DMS rules testing
- ❑ Commitment to communication
  - Scheduled and ad hoc meetings
  - Growth through positive initiatives
  - Removal of unnecessary barriers

Provider Tools & Resources

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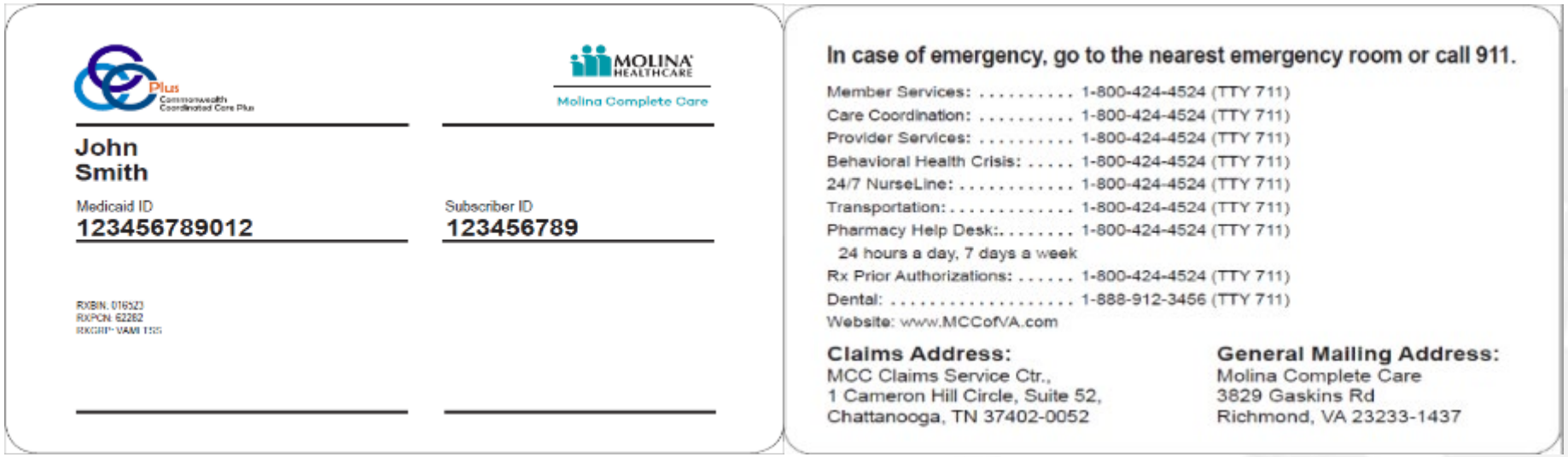
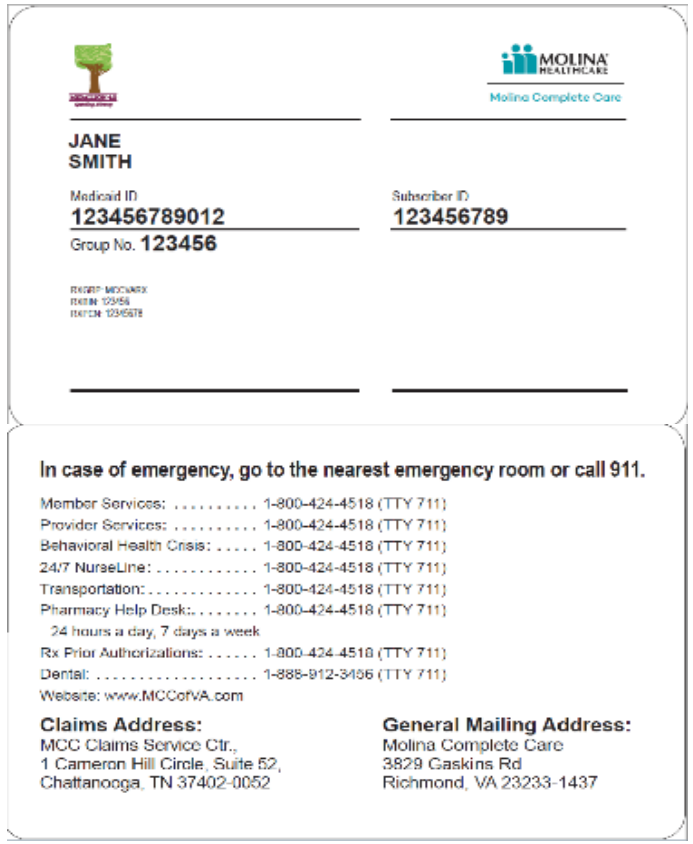
CCC Plus Member ID Card

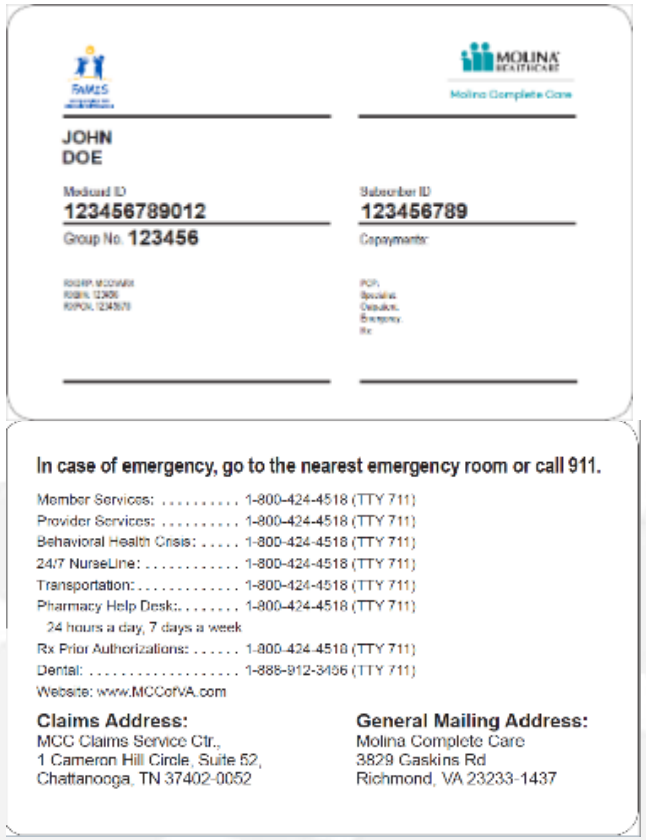


Medallion 4.0 and FAMIS Member ID Cards

Medallion 4.0



FAMIS



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Molina Healthcare of VA DSNP Member ID Card

Provider Manual

Molina's Provider Manuals are written specifically to address the requirements of delivering healthcare services to our members, including the responsibilities of our participating providers. Providers may view the manual on our provider website, at:

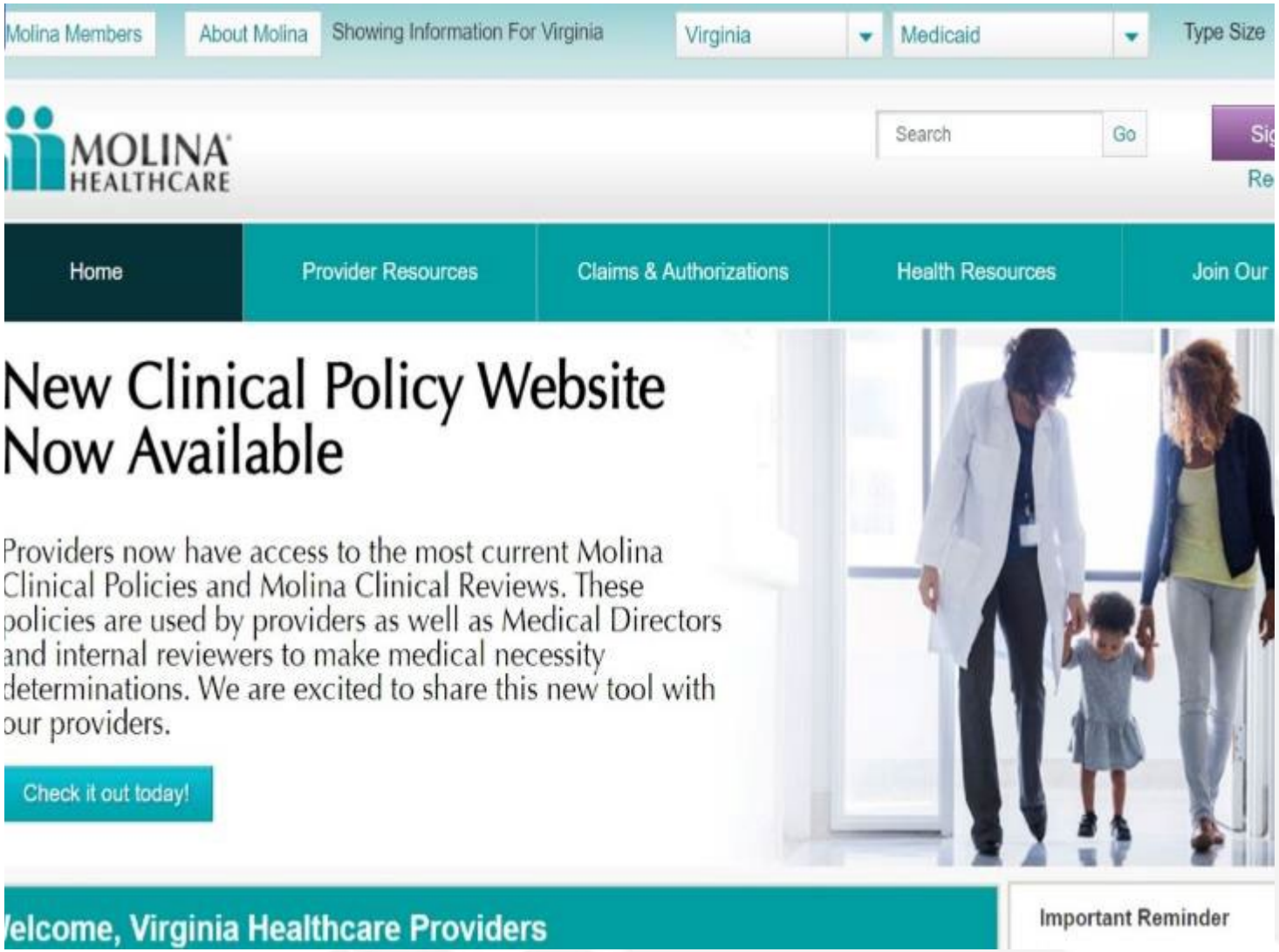
- https://www.molinahealthcare.com/providers/va/medicaid/resources/provider-materials.aspx

Provider Manual Highlights	
▪ Benefits and Covered Services Overview	▪ Long Term Supports and Services
▪ Claims, Encounter Data and Compensation (including the no balance billing requirements)	▪ Member Grievances and Appeals
▪ Compliance and Fraud, Waste, and Abuse Program	▪ Member Rights and Responsibilities
▪ Contacts	▪ Model of Care
▪ Credentialing and Re-credentialing	▪ Pharmacy
▪ Utilization Management, Referral and Authorization (Healthcare Services)	▪ Preventive Health Guidelines
▪ Eligibility, Enrollment, and Disenrollment	▪ Provider Responsibilities
▪ Health Management (Health Education & Disease Management)	▪ Quality Improvement
▪ Health Insurance Portability and Accountability Act (HIPAA)	▪ Transportation Services
▪ Interpreter Services	

Provider Online Resources

- Provider Online Directories
- Preventative & Clinical Care Guidelines
- Provider Manuals
- Provider Portal
- Prior Authorization Information
- Advanced Directives
- Model of Care Training
- Claims Information
- Pharmacy Information
- HIPAA
- Fraud Waste and Abuse Information
- Frequently Used Forms
- Communications & Newsletters
- Member Rights & Responsibilities
- Contact Information

MolinaHealthcare.com



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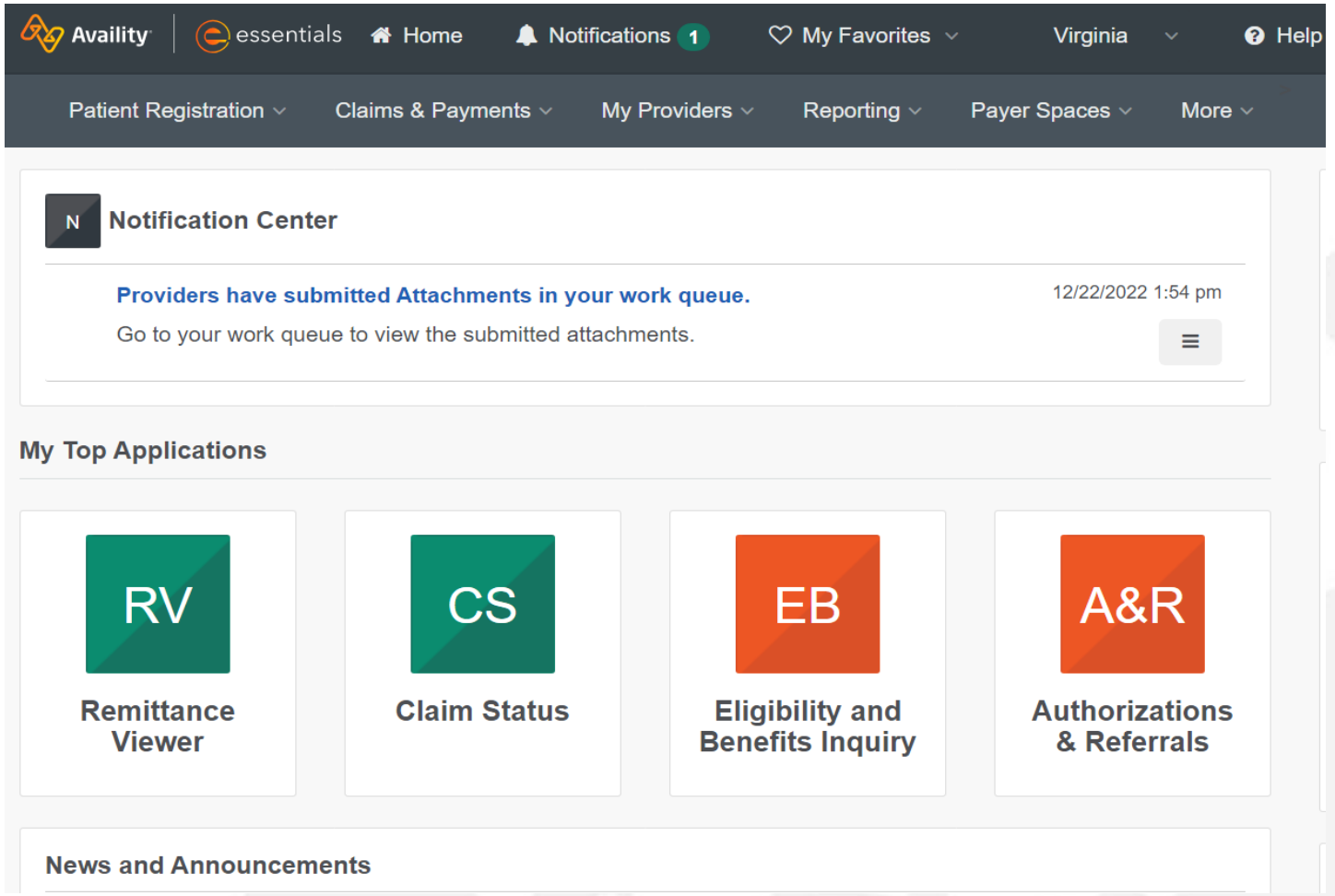
Molina Provider Portal

Molina utilizes Availity for our Provider Portal. Providers may register for access to our Provider Portal for services that include self service member eligibility, claim status, provider searches, to submit requests for authorizations and to submit claims.

Services Offered by Availity and Molina:

- **Claim Submission/resubmission**
- **Claim Status**
- **Remittance Viewer**
- **Obtaining Member Eligibility & Benefits**
- **Submitting Authorization Requests**
- **HEDIS Information**



Organization Registration Resource – http://www.availity.com/registration-tips
Support Availity Client Services is available at 1-800-AVAILITY (1-800-282-4548) , Monday to Friday from 8 a.m. to 7 p.m. ET.

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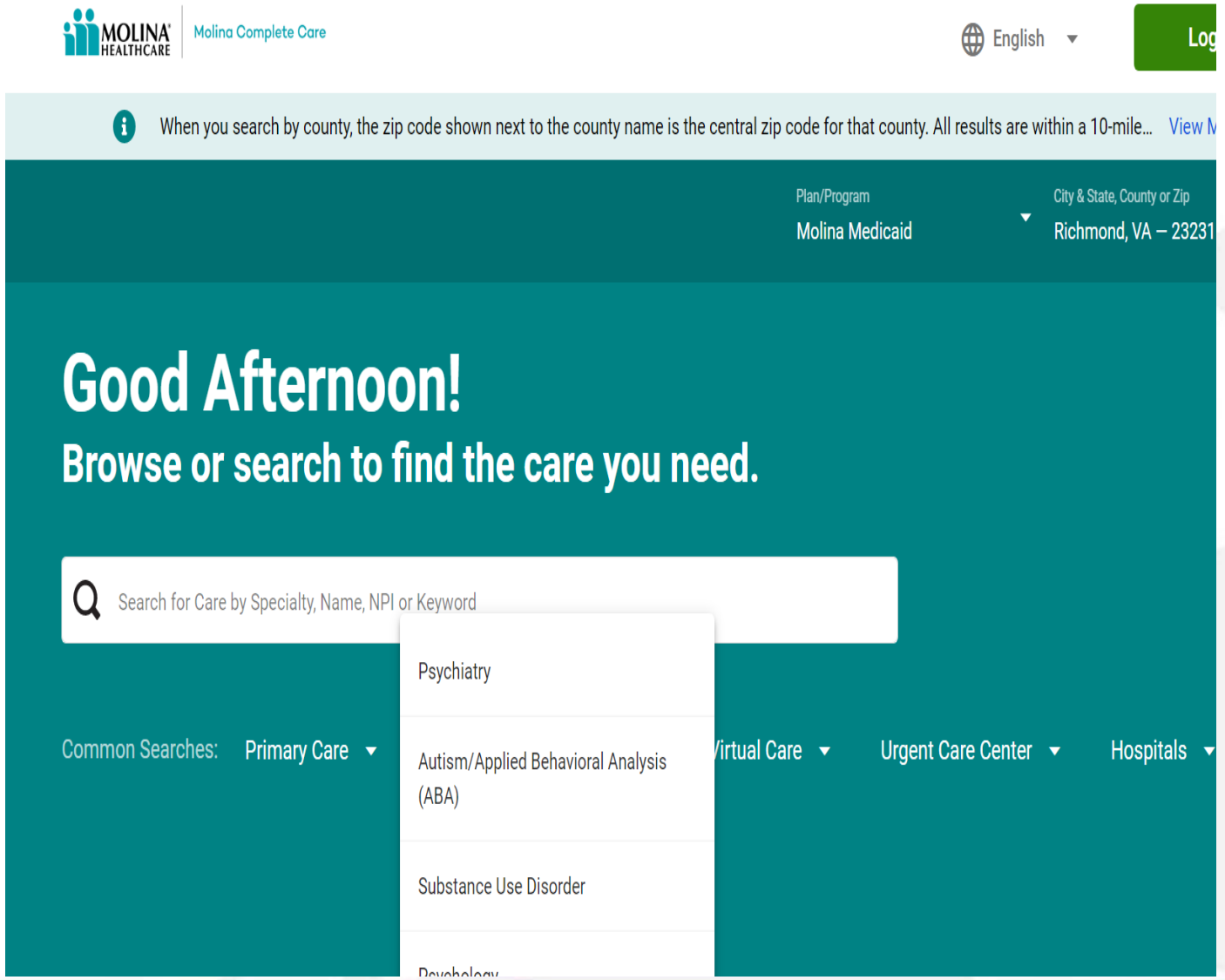
New Provider Online Directory

Providers may use Molina's Provider On-line Directory (POD) located on our website or request a copy of the Provider Directory from their Provider Services Representative(s).

Molina is committed to improving your online experience. The new Provider Online Directory enhances search functionality so information is available quickly and easily.

Key benefits include:

- User-friendly and intuitive navigation
- Provider profile cards for quick access to information
- Browsing by category, search bar and common searches
- Expanded search options and filtering for narrowing results
- Provider information you can save to use later



Behavioral Health Services

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Project Bravo
Phase II – Services began effective 12/1/2021

Molina Healthcare of Virginia covers the following services through the Behavioral Health Expansion Phase II (please note: these services will require prior authorization):

- Multisystemic Therapy (MST)
- Functional Family Therapy (FFT)
- Mobile Crisis
- Community Stabilization
- 23-Hour Crisis Stabilization
- Residential Crisis Stabilization
- Applied Behavior Analysis

The above services replaced the following:

- Behavioral Therapy
- Crisis Intervention
- Crisis Stabilization

MOLINA HEALTHCARE

Project Bravo (cont'd)
Phase II – Services began effective 12/1/2021

Multisystemic Therapy (MST) - MST is an intensive family and community-based treatment, which addresses the externalizing behaviors of youth with significant clinical impairment in disruptive behavior, mood, and/or substance use. MST is provided using a home-based model of service delivery for youth and families, targeting youth between the ages of 11 - 18 who are at high risk of out- of-home placement, or may be returning home from a higher level of care.

Functional Family Therapy (FFT) - FFT is a short-term, evidence-based treatment program targeting youth between the ages of 11 - 18 who have received referral for the treatment of behavioral or emotional problems including co-occurring substance use disorders by the juvenile justice, behavioral health, school, or child welfare systems. FFT is a primarily home-based service that addresses both symptoms of serious emotional disturbance in the identified youth, as well as parenting/caregiving practices and/or caregiver challenges that affect the youth and caregiver's ability to function as a family. The FFT model serves as a step-down or diversion from higher levels of care and seeks to understand and intervene with the youth within their network of systems including, family, peers, school and neighborhood/community.

Project Bravo (cont'd)
Phase II – Services began effective 12/1/2021

Mobile Crisis Response - Mobile Crisis Response provides rapid response, assessment and early intervention to individuals experiencing a behavioral health crisis. This service is provided 24 hours a day, seven days a week. The purpose of this service includes prevention of acute exacerbation of symptoms, prevention of harm to the individual or others, provision of quality intervention in the least restrictive setting, and development of an immediate plan to maintain safety in order to prevent the need for a higher level of care. The current code for Crisis Intervention (H0036) will be replaced by the Mobile Crisis Response service, as this is an enhancement of the current Crisis Intervention service for Both youth and adults.

Community Stabilization – Community Stabilization services are short-term and designed to support an individual and their natural support system following contact with an initial crisis response service or as a diversion to a higher level of care. Providers deliver Community stabilization services in an individual's natural environment and provide referral and linkage to other community-based services at the appropriate level of care. Interventions may include: brief therapeutic and skill-building interventions, engagement of natural supports, interventions to integrate natural supports in the de-escalation and stabilization of the crisis, and coordination of follow-up services. Community Stabilization will replace and serve as an enhancement of the current Crisis Stabilization service for both youth and adults.

Project Bravo (cont'd)
Phase II – Services began effective 12/1/2021

23-Hour Crisis Stabilization - 23-Hour Crisis Stabilization provides a period of up to 23 hours in a community-based setting for crisis stabilization that provides assessment and stabilization interventions to individuals experiencing a behavioral health crisis. This service should be accessible 24/7 and is indicated for those situations wherein an individual is in an acute crisis and requires a safe environment for observation and assessment prior to determination of whether admission to an inpatient or residential crisis stabilization unit setting is necessary. This service allows for an opportunity for thorough assessment of crisis and psychosocial needs and supports throughout the full 23 hours of service to determine the best resources available for the individual to prevent unnecessary hospitalization.

Residential Crisis Stabilization Unit (RCSU) - RCSUs provide short-term, 24/7, residential psychiatric/substance related crisis evaluation and brief intervention services. RCSUs serve as diversion or stepdown from inpatient hospitalization. The service supports individuals experiencing abrupt and substantial changes in behavior noted by severe impairment or acute decompensation in functioning.

Project Bravo (cont'd)
Phase II – Services began effective 12/1/2021

Applied Behavior Analysis - Applied Behavior Analysis means the practice of behavior analysis as established by the Virginia Board of Medicine in § 54.1-2900 as the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Applied Behavior Analysis will replace and serve as an enhancement of our current Behavior Therapy service for youth. DBHDS licensing is not applicable for this service.

Providers are encouraged to connect members to participating providers for these services as needed. Please visit the DMAS website (Home - Department of Medical Assistance Services (virginia.gov)) for complete service descriptions and details or you can contact Molina's Customer Service Department at: (800) 424-4524 for assistance.

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ARTS
Addiction & Recovery Treatment Services

Starting in 2017, Virginia Medicaid undertook a series of reforms to expand access to care for individuals with Substance Use Disorders (SUD). This included the implementation of a new benefit called Addiction and Recovery Treatment Services (ARTS).

ARTS provides the full continuum of evidence-based addiction treatment to ensure members are matched to the appropriate level of care to meet their evolving needs as they enter and progress through treatment.

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ARTS (Addiction and Recovery Treatment Services)

ASAM Level of Care	ASAM Description
4.0	**Medically Managed Intensive Inpatient (H0011 or Rev 1002)**
3.7	**Medically Monitored Intensive Inpatient Services (Adult) (H2036/Rev 1002 modifier HB)** **Medically Monitored High-Intensity Inpatient Services (Adolescent) (H2036/Rev 1002 modifier HA)**
3.5	**Clinically Managed High-Intensity Residential Services (Adults)/ Medium Intensity (Adolescent) (H0010/Rev 1002 modifier HB/HA)**
3.3	**Clinically Managed Population-Specific High-Intensity Residential Services (Adults) (H0010/Rev 1002 modifier TG)**
3.1	**Clinically Managed Low-Intensity Residential Services (H2034)**
2.5	Partial Hospitalization Services **(S0201 and Rev 0913)**
2.1	Intensive Outpatient Services **(H0015 and Rev 0906)**
2WM and 1WM	Ambulatory Withdrawal Management With and Without monitoring (CPT codes)
1.0	Outpatient Services (Individual, Group and Family Counseling) (CPT codes)
OTS (*Opioid Treatment Services)*	Medication Assisted Treatment (MAT): Opioid Treatment Program (OTP) *includes Methadone and Buprenorphine/Naloxone*
OTS (*Opioid Treatment Services)*	Medication Assisted Treatment (MAT): Office-Based Opioid Treatment (OBOT) *includes Buprenorphine/Naloxone*
0.5	Early Intervention/Screening Brief Intervention and Referral to Treatment (SBIRT) (99408/99409)
n/a	Substance Abuse Case Management (H0006)
n/a	ARTS Peer Support Recovery Services (GRP: S9445, INDV T1012)

For Levels 3.1-4.0: MCO shall provide coverage in IMD settings as appropriate based on the ASAM criteria for adults 21-64 years of age.

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Applied Behavioral Analysis

Applied Behavior Analysis (ABA) is the practice of applying the psychological principles of learning theory in a systematic way to modify behavior. The practice is used most extensively in special education and the treatment of autism spectrum disorder (ASD).

Applied Behavioral Analysis (cont'd)

Service Name	Procedure Code	Modifier	Modifier Meaning	Rate (per 15 minutes)
Applied Behavior Analysis	97151 Individual Assessment	HO	Licensed Behavior Analyst (LBA)	$41.45
		TF	LMHP	$35.02
		HN	Licensed Assistant Behavior Analyst (LABA)*	$20.87
	97152 Individual Assessment	HN	LABA	$20.87
		none	Technician level	$13.33
	97153 Individual Treatment	HO	LBA	$41.45
		TF	LMHP	$35.02
		HN	LABA	$20.87
		none	Technician level	$13.33
	97154 Group Treatment	HO	LBA	$13.82
		TF	LMHP	$11.67
		HN	LABA	$13.87
		none	Technician level	$11.35
	97155 Individual Treatment	HO	LBA	$41.45
		TF	LMHP	$35.02
		HN	LABA*	$20.87
	97156 Family Training	HO	LBA	$41.45
		TF	LMHP	$35.02
		HN	LABA*	$20.87
	97157 Group Family Training	HO	LBA	$13.82
		TF	LMHP	$11.67
		HN	LABA*	$6.96

Applied Behavioral Analysis (cont'd)

	97158 Group Treatment	HO	LBA (additional staff with child)	$27.15
		TF	LMHP (additional staff with child)	$25.00
		HN	LABA* (additional staff with child)	$20.29
	0362T Team Functional Analysis	HO	LBA and two staff	$68.11
		TF	LMHP and two staff	$61.68
		HN	LABA* and two staff	$47.53
	0373T Team Modified Treatment	HO	LBA and two staff	$68.11
		TF	LMHP and two staff	$61.68
		HN	LABA* and two staff	$47.53

Contracting/Credentialing Requirements

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DMAS Registration Portal (MES)

The Virginia Department of Medical Assistance Services (DMAS) has launched a new portal, to manage Medicaid provider enrollment. All Medicaid managed care providers are required to enroll on this portal.

- As a Molina participating provider, you will need to initiate enrollment through the new PRSS enrollment wizard, located here: Home | MES (virginia.gov).
- Go to "New Provider Enrollment" and follow the prompts. Only one enrollment application is necessary in PRSS, even if you participate with more than one MCO.
- The application process allows for selection of one or more MCO plans (**Select Molina**). Once approved, providers will need to create a PRSS portal online account in order to revalidate their enrollment, make changes to personal or business information, add/update participating MCO's and check member eligibility.
- You may be asked to provide evidence of your submission. You can find helpful training resources on the MES website, here: https://vamedicaid.dmas.virginia.gov/provider.
- Contact PRSS Provider Enrollment Helpline at (804) 270-5105 or (888) 829-5373, or email Provider Enrollment at: vamedicaidproviderenrollment@gainwelltechnologies.com.

Credentialing Required Documents

Register on DMAS Portal First

Facility Documents

- Health Delivery Organization (HDO) Application
- MHI Ownership and Control Disclosure Form
- Virginia Guide to Provider Information Form (PIF)
- W9 (*Legal name must match, as registered with IRS. Address must match billing/payment address)*
- General/Professional Liability Insurance
- Licenses for all services you provide
- Staff Roster (if applicable)

Please refer to Molina's website:

Provider Forms | Molina Complete Care (molinahealthcare.com)

Credentialing Required Documents (cont'd)

Register on DMAS Portal First

Group/Practitioner Documents

- Virginia Guide to Provider Information Form (PIF)
- W9 (*Legal name must match, as registered with IRS. Address must match billing/payment address)*
- Staff Roster
- Please refer to Molina's website:

Provider Forms | Molina Complete Care (molinahealthcare.com)

For those groups/practices/providers administering ARTS services, please also include appropriate ARTS forms (ARTS attestation form/ARTS roster).

Utilization Management

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Utilization Management

Our Utilization Management (UM) program functions by:

- Assuring that services are Virginia Medicaid and Check Up (CHIP) covered benefits
- Experimental and Investigational may be approved for members <21 following Federal EPSDT guidelines
- Applying nationally accepted evidence-based criteria that support decision making to determine the medical necessity or appropriateness of services
- Monitoring of our members benefits to ensure a safe discharge plan with appropriate follow up services

Referrals and Prior Authorization

Referrals are made when medically necessary services are beyond the scope of the PCPs practice. Most referrals to in-network specialists do not require an authorization from Molina.

Information is to be exchanged between the PCP and Specialist to coordinate care of the patient.

- Prior Authorization is a request for prospective review. It is designed to:

  - ✓ Assist in benefit determination
  - ✓ Prevent unanticipated denials of coverage
  - ✓ Create a collaborative approach to determining the appropriate level of care for Members receiving services
  - ✓ Identify Case Management and Disease Management opportunities
  - ✓ Improve coordination of care

Requests for services listed on the Molina Healthcare Prior Authorization Guide are evaluated by licensed nurses and trained staff that have the authority to approve services.

A list of services and procedures that require prior authorization is included in our Provider Manual and is also posted on our website at: **https://www.molinahealthcare.com/providers/va/medicaid/claims/authorization.aspx**

Utilization Management/Authorization

- **Provider portal**

Please use this new link to access your Molina payer spaces in the Availity Essentials portal: availity.com/molinahealthcare.

- **Prior authorization look-up tool**

The prior authorization (PA) look-up tool is an interactive tool to help providers, members and Molina Healthcare staff determine prior authorization requirements, including whether a code requires require prior authorization. You can find this tool on our provider website: molinahealthcare.com/members/va/en-us/health-care-professionals/home.aspx.

- **Prior authorization list**

As part of our effort to ease provider administrative work and help our members live healthier lives, we continue to refine our PA requirements. We do this by adding and removing PA requirements for certain medications and services.

The PA list can be accessed on our provider site under the "Authorizations/Utilization Management" heading at molinahealthcare.com/providers/va/medicaid/resources/forms.aspx.

Utilization Management/Authorization (cont'd)

Fax requests for authorization

We have reconfigured our fax intake process based on services requested versus a member's plan in preparation for Cardinal Care. Please use the prior authorization request form for all fax requests, which you can find at molinahealthcare.com/providers/va/medicaid/resources/forms.aspx

Decisions on routine prior authorizations will be rendered within 14 calendar days from the date of receipt of the request. Decisions on expedited prior authorizations requests will be rendered within 72 hours from the date we receive the request if we determine that the request qualifies for expedited consideration.

Contact Provider Services if you have not received a response after waiting the required number of days.

- CCC Plus (800) 424-4524
- Medallion 4.0 (800)424-4518

Utilization Management/Authorization (cont'd)

Service requested for CCC Plus & Medallion 4.0 plans	Fax number
Inpatient physical health	(866) 210-1523
Outpatient physical health	(855) 769-2116
Long Term Support Services (LTSS)	(800) 614-8207
Behavioral health	(855) 339-8179
Maternity	(866) 210-1523
Advanced imaging	(877) 731-7218
Transplant	(877) 813-1206
Pharmacy	(844) 278-5731
Virginia DSNP Medicare	(888) 656-2389
Care coordination documents (newborn notification, UAI, IFSP, etc.)	(800) 614-7934

Request Responses

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

For a standard authorization request, Molina makes the determination and provides response within fourteen (14) calendar days.

For an expedited request for authorization, Molina makes a determination as promptly as the member's health requires and no later than seventy-two (72) hours after Molina receives the initial request for service. In the event a provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a member's life or health, Molina will process such requests as expedited as well.

Prior Authorization Review Guide

Molina® Healthcare Medicaid
Prior Authorization/Pre-Service Review Guide
Effective: 01/01/2021

Refer to Molina's Provider website or Prior Authorization Look-up Tool/Matrix for specific codes that require authorization
Only covered services are eligible for reimbursement

Office visits to Contracted/Participating (PAR) Providers & Referrals to Network Specialists Do Not Require Prior Authorization.
Emergency Services Do Not Require Prior Authorization.

- **Advanced Imaging and Special Tests**
- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, Partial Hospitalization, Day Treatment, Intensive Outpatient, Targeted Case Management
  - Electroconvulsive Therapy (ECT)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD)
- **Cosmetic, Plastic and Reconstructive Procedures:** No PA required with Breast Cancer Diagnoses
- **Durable Medical Equipment**
- **Elective Inpatient Admissions:** Acute Hospital, Skilled Nursing Facilities (SNF), Acute Inpatient Rehabilitation, Long Term Acute Care (LTAC) Facilities
- **Experimental/Investigational Procedures**
- **Genetic Counseling and Testing** (Except for prenatal diagnosis of congenital disorders of the unborn child through amniocentesis and genetic test screening of newborns mandated by state regulations)
- **Healthcare Administered Drugs**
- **Home Healthcare Services (including home-based PT/OT/ST)**
- **Hyperbaric/Wound Therapy**
- **Long Term Services & Support (Per State benefit):** All LTSS services require PA regardless of code(s).
- **Miscellaneous & Unlisted Codes:** Molina requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale must be submitted with the prior authorization request.
- **Neuropsychological and Psychological Testing**
- **Non-Par Providers/Facilities:** PA is required for office visits, procedures, labs, diagnostic studies, and inpatient stays except for:
  - Emergency and Urgently Needed Services;
  - Professional fees for Medicaid enrolled providers associated with ER visits and approved Ambulatory Surgery Center (ASC) or inpatient stays;
  - Local Health Department (LHD) services;
  - Radiologists, anesthesiologists, and pathologists professional services when billed in POS 19, 21, 22, 23 or 24;
  - PA is waived for professional component services or services billed from Medicaid enrolled providers with Modifier 26 in ANY place of service setting;
  - Other State mandated services.
- **Nursing Home/Long Term Care**
- **Occupational, Physical & Speech Therapy**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery**
- **Sleep Studies**
- **Transplants/Gene Therapy, including Solid Organ and Bone Marrow:** (Cornea transplant does not require authorization)
- **Transportation Services:** Non-emergent air transportation

Prior Authorization Review Guide (cont'd)

*Molina requires notification of all emergent inpatient admissions within twenty-four (24) hours of a*dmission *or by the close of the next business day when emergent admissions occur on weekends or holidays.*

- For emergency admissions, notification of the admission shall occur once the patient has been stabilized in the emergency department.
- Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate inpatient review and discharge planning.

We require that the notification includes:

- Member demographic information,
- Facility information,
- Date of admission and
- Clinical information sufficient to document the Medical Necessity of the admission.
- Emergent inpatient admission services performed without meeting notification and Medical Necessity requirements or failure to include all of the needed documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient admission.
- Molina performs concurrent inpatient review in order to ensure patient safety, Medical Necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Molina will request updated original clinical records from inpatient facilities at regular intervals during a Member's inpatient admission. *This information is due from the inpatient facility within twenty-four (24) hours of the request.*

Molina Partners - Pharmacy

CVS/Caremark is the Pharmacy Benefit Manager (PBM) for Molina Healthcare.

The “Formulary”, also known as the “Preferred Drug List” (PDL), is available on the Molina Healthcare website: https://www.molinahealthcare.com/providers/va/medicaid/resources/pharmacy.aspx

The formulary was created to help manage the quality of our Members’ pharmacy benefit; it is the cornerstone for a progressive program of managed care pharmacotherapy. Prescription drug therapy is an integral component of a patient's comprehensive treatment program and the formulary was created to ensure that our members receive high quality, cost-effective, rational drug therapy.

Prescriptions for medications requiring prior approval, for most injectable medications or for medications not included on the formulary may be approved when medically necessary and when formulary alternatives have demonstrated ineffectiveness. When these exceptional needs arise, providers may fax a completed Prior Authorization/Medication Exception Request.

Phone:
CCC Plus: (800) 424-4524
Medallion 4.0: (800) 424-4518

Prior Authorization Fax: (844) 278-5731

The Prior Authorization Request Form is included in the Orientation Kit and is also available on our website: molinahealthcare.com/providers/va/medicaid/resources/forms.aspx

Access Standards

Molina Healthcare monitors compliance and conducts ongoing evaluations regarding the availability and accessibility of services to Members. Please ensure adherence to these regulatory standards:

Behavioral Health Appointment Types	Standard
Life Threatening Emergency	Immediately
Non-Life Threatening Emergency	Within 6 hours
Urgent Care	Within 72 Hours
Behavioral Health/Substance Use Disorder Providers Routine Visit	Not to exceed 30 calendar days
Follow-up Routine Care	Within 2 weeks

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

Nurse Advice Line

This telephone-based nurse advice line is available to all Molina Members. Members may call anytime they are experiencing symptoms or need health care information. Registered nurses are available **(24) hours a day, seven (7) days a week** to assess symptoms and help make good health care decisions.

Nurse Advice Line (NAL) **24 hours per day, 365 days per year**
CCC Plus: (800) 424-4524 Medallion 4.0: (800) 424-4518 TTY/TDD: 711 Relay

Note: The Nurse Advice Line telephone number is also printed on member ID cards. Includes Behavioral Health: BH Crisis Line only

Claims

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Electronic Funds Transfer (EFT) and Electronic Remittance Advise (ERA)

Contracted Providers should register with Change Healthcare and ECHO Health, Inc.(Electronic Funds Transfer (EFT)) within 30 days of receiving their first reimbursement check from Molina.

- Providers enrolled in EFT payments will automatically receive Electronic Remittance Advices (ERAs) as well.
- Additional information regarding EFTs and ERAs is available under the “EDI, ERA/EFT” tab on the Molina website.

Benefits of EFT/ERA:

- Faster payment (as little as 3 days from the day the claim was electronically submitted)
- Search historical ERAs by claim number, member name, etc.
- View, print, download and save PDF ERAs for easy reference
- Providers can have files routed to their ftp and/or their associated clearinghouse

How to Enroll:

- To register for ECHO Health go to: https://enrollments.echohealthinc.com/EFTERADirect/MolinaHealthcare
- Step-by-step registration instructions are available on Molina’s website (https://www.molinahealthcare.com/providers/va/medicaid/home.aspx) under the “EDI, ERA/EFT” tab.
- Questions? Contact ECHO Health at (888) 834-3511

Claims

Claims Processing Standards – On a monthly basis, over 90% of claims received by Molina from our health plan network providers are processed within 30 calendar days;100% of claims are processed within 90 working days

- These standards have to be met in order for Molina to remain compliant with regulatory requirements and to ensure that our providers are paid in a timely manner

Claims Submission Options

- Molina requests that contracted providers submit all claims electronically.
- Electronic claims include claims submitted via a clearinghouse using the EDI process and claims submitted through the Molina Provider Web Portal.
- The Provider Portal (Availity.com/molinahealthcare) is available free of charge and allows for attachments to be included. You will need to have a premium subscription with Availity to submit EDI batch claims.
- Via a Clearinghouse.
  - Providers may use the Clearinghouse of their choosing. (Note that fees may apply).
  - Change Healthcare is Molina Healthcare's chosen clearinghouse. When submitting EDI Claims (via a clearinghouse) to Molina Healthcare, providers must use the applicable ***payer ID: MCC02***

EDI Claim Submission Issues

- Providers can call the EDI customer service line at **(866) 409-2935**; and/or
- Submit an email to EDI.Claims@molinahealthcare.com.

Claims Submission Guidelines

Molina's Provider Portal

- Free registration; contact a Molina Provider Services call center agent to obtain the Molina Provider ID # required to register
- Allows for submission of UB and CMS 1500 claims, including claims with attachments and corrected claims
- ***The web portal is the recommended method to submit claims with attachments.***

The portal can be accessed at: Availity.com/molinahealthcare

When submission of an Electronic claim is not possible, paper claims may be submitted to the following address:

Molina Complete Care
PO Box 22656
Long Beach, CA 90801

Claims Submission Options

EDI Claims Submission Information

Clearinghouse:

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

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

- Change Healthcare Payer ID# ***MCC02***

EDI Claim Submission Issues

- Please call the EDI customer service line at **(866) 409-2935**; and/or
  - Submit an email to EDI.Claims@molinahealthcare.com; and/or
  - Contact your provider services representative at MCCVA-Provider@MolinaHealthcare.com

Claims Submission – Timely Filing

Providers are encouraged to submit claims for Covered Services rendered to members as soon as possible following the date of service.

- Claims must be submitted by provider to Molina Healthcare ***within one hundred eighty (180) calendar days*** after the following have occurred: discharge for inpatient services or the date of service for outpatient services; and provider has been furnished with the correct name and address of the member's health maintenance organization.
- All claims shall be submitted in a form acceptable to and approved by Molina Healthcare, and shall include any and all medical records pertaining to the claim if requested by Molina Healthcare or otherwise required by Molina Healthcare's policies and procedures.
- If Molina Healthcare is not the primary payer under coordination of benefits or third party liability, provider must submit claims to Molina Healthcare ***within one hundred-eighty (180) calendar days*** after the final determination is made by the primary payer.
- Except as otherwise provided by law, any claims that are not submitted to Molina Healthcare within these timelines shall not be eligible for payment, and provider hereby waives any right to payment therefore.
- NOTE: Clean claim timely filing is 180 days (In State Providers) and 365 days (Out Of State Providers)

Claims Submission and Disputes

Corrected Claims

Corrected claims are considered to be new claims.

- Corrected claims may be submitted electronically via the Provider Portal, through an EDI clearinghouse or on paper
- Corrected claims must include the correct coding to denote if a claims is a Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P. (See the Provider Manual for additional details on how to correctly include this coding.)

Claims Reconsideration

Providers seeking a redetermination of a claim previously adjudicated must request such action within ninety (90) days of Molina Healthcare's original remittance advice date. Additionally, any claim(s) dispute requests (including denials) should be submitted to Molina Healthcare using the standard claims reconsideration review form (CRRF). This form can be found on the provider website.

In addition to the CRRF, providers should submit the following documentation:

- The previous claim and remittance advice, any other documentation to support the adjustment and a copy of the Service Authorization form (if applicable) must accompany the adjustment request.
- The claim number clearly marked on all supporting documents.
- Forms may be submitted via fax or mail. See the Provider Manual for the mailing address and fax number.

Claims—Coordination of Benefits

- Medicaid is the payer of last resort; private and governmental carriers must be billed prior to billing Molina Healthcare
- Provider should inquire with Members to learn whether Member has health insurance, benefits or Covered Services other than from Molina Healthcare
- Provider must immediately notify Molina Healthcare of any other coverage
- Provider will be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers and payers, not to exceed Molina Healthcare's contracted allowable rate.
- Provider must include a copy of the other insurance's EOB with the Claim.

Providers can submit claims free of charge with attachments, including EOBs and other required documents, by utilizing Molina's Provider Portal.

Claims—Third Party Liability

- Molina Healthcare as payer of last resort will make every effort to determine the appropriate Third Party payer for services rendered.
- Molina may deny claims when a Third Party has been established and will pay claims for covered services when probable Third Party Liability (TPL) has not been established or third party benefits are not available to pay a claim.
- Molina Healthcare will attempt to recover any third-party resources available to members and shall maintain records pertaining to TPL collections on behalf of members for audit and review.

***Note**: Molina complies with Federal law(s) which require Medicaid Payers to reimburse for certain covered services even when a third party source exist. In these instances, Molina will reimburse the provider for specific covered services, and then pursue recover of the Medicaid payment from the third party source.*

Claim Appeals

A Provider may file an Appeal orally or in writing. An Appeal is a request for Molina to review an Adverse Benefit Determination related to a provider; which may include, but is not limited to, for cause termination by the Molina, or delay or non-payment for covered services.

- Appeals must be filed within thirty (30) calendar days from the Adverse Benefit Determination or denial. A written acknowledgement letter must be sent within ten (10) calendar days of receipt of the Appeal.
- Appeals must be resolved as expeditiously as possible: no later than thirty (30) calendar days from receipt.
- The timeframe for Appeals resolution may be extended up to fourteen (14) calendar days in compliance with state regulation.
- For decisions not resolved wholly in the provider's favor, Providers have the right to request a state Administrative Hearing from the Division of Medicaid.

Appeals & Grievances

Providers have the right to file a complaint, grievance or appeal through a formal process. The Division of Medicaid shall have the right to intercede on a provider's behalf at any time during the contractor's Complaint, Grievance, and/or Appeal process whenever there is an indication from the Provider, or, where applicable, authorized person, that a serious quality of care issue is not being addressed timely or appropriately.

Written acknowledgement letters will be sent within five (5) calendar days of receipt of the Grievance by Molina. All Grievances will be resolved as expeditiously as possible; all will be resolved no later than thirty (30) calendar days from receipt.

Providers may file a complaint or formal grievance by contacting Molina
toll-free at **CCC PLUS: (800) 424-4524**
Medallion 4.0: (800) 424-4518
Mon. - Fri. 8:00 a.m. to 6:00 p.m. ET, excluding State holidays

Grievances may also be submitted in writing to our Regional Appeals & Grievances Team:
Appeals and Grievance Department
Molina Healthcare, INC
P. O. Box 36030
Louisville, KY 40233-6030
Fax (866) 4325-9157

MOLINA HEALTHCARE

Balance Billing and Claims Payment

Providers *may not* balance bill Molina Members for any reason for *covered* services. Detailed information regarding the billing requirements for non-covered services are available in the Provider Manual.

Your Provider Agreement with Molina requires that your office verify eligibility prior to rendering any service and obtain approval for those services that require prior authorization.

In the event of a denial of payment, providers shall look solely to ***Molina*** for compensation for services rendered, with the exception of any applicable cost sharing/co-payments.

- ✓ The date of claim receipt is the date as indicated by its data stamp on the claim.
- ✓ The date of claim payment is the date of the check or other form of payment.

Behavioral Health Provider Services Managers

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MOLINA HEALTHCARE

Provider Services Managers

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