BA Services Provider Orientation

Molina Healthcare of Florida, Inc.

Provider Engagement Team

2025

MOLINA® HEALTHCARE

You Matter to Molina

Agenda

1. About Molina
2. We are here for you
3. Behavior Analysis (BA)
4. Claims
5. Telehealth
6. Availity Portal
7. PML Enrollment Requirements
8. Credentialing

Agenda

9 Authorizations

10 Continuity of Care (COC)

11 Data Management & Provider Online Directory (POD)

12 Provider Disputes & Appeals

13 Fraud, Waste, and Abuse

14 Provider Online Resources

About Molina Healthcare of FL

MOLINA® HEALTHCARE

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About Us and Our Mission

Molina believes every person, family and community deserves access to high-quality health care regardless of their situation. Our mission is to deliver effective, reliable and affordable health care to those who need it most. We strive to meet the physical, social and emotional needs of each member and to strengthen the communities we serve.
We do this by offering a holistic, community-based approach designed specifically to meet the individual needs of our members.

What started in 1980 as one clinic in Long Beach, aimed at addressing the disparities in access to quality health care, has grown into 18 health plans across the country. For over 40 years, we've been improving the lives of our 5.1 million members across the country by pioneering health care services exclusively for those with government-sponsored health care.

Molina Healthcare of Florida
8300 NW 33rd St., Suite 400
Doral, FL 33122

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Molina Healthcare, Inc.

States	
• Arizona	• South Carolina
• California	• Texas
• Florida	• Utah
• Idaho	• Virginia
• Illinois	• Washington
• Kentucky	• Wisconsin
• Massachusetts	
• Michigan	
• Nevada	
• New Mexico	
• New York	
• Ohio	

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Molina Healthcare of Florida Facts

Molina Healthcare of Florida has been providing government-funded, quality health care since 2008

We partner with local organizations that support the overall health and well-being of Floridians, educational events, toy drives, and food distribution.

Local Partners

- Farm Share
- Camillus House
- Bridge to Hope

Visit our In Your Community page to learn more

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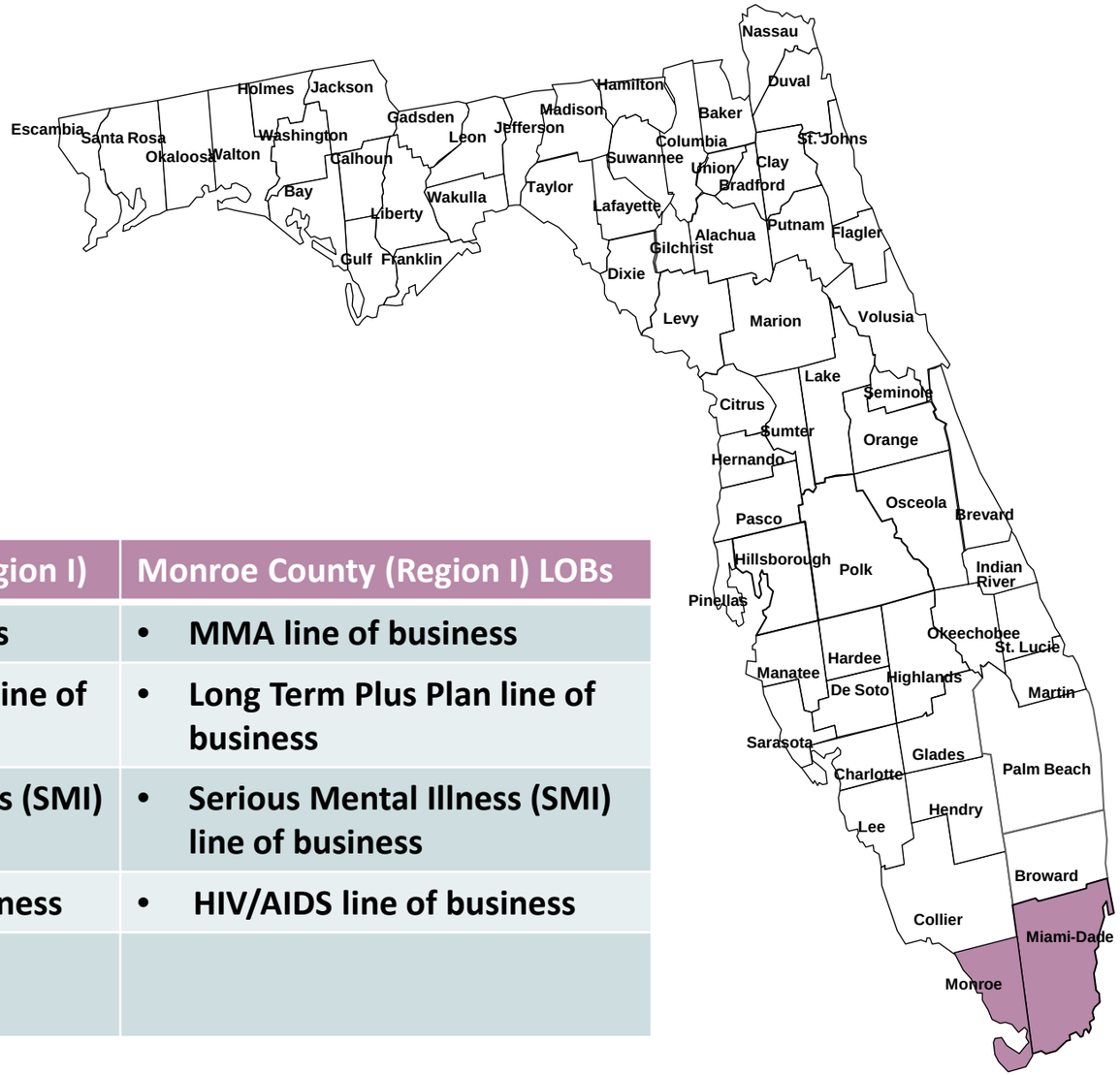
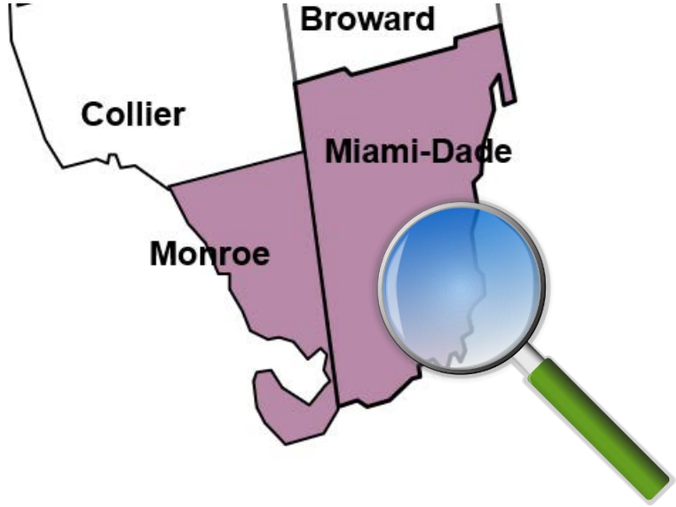
Health Plan Territory Map 2025





Miami-Dade County (Region I)	Monroe County (Region I) LOBs
• MMA line of business	• MMA line of business
• Long Term Plus Plan line of business	• Long Term Plus Plan line of business
• Serious Mental Illness (SMI) line of business	• Serious Mental Illness (SMI) line of business
• HIV/AIDS line of business	• HIV/AIDS line of business
• Marketplace line of business	

Provider Support

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Provider Support

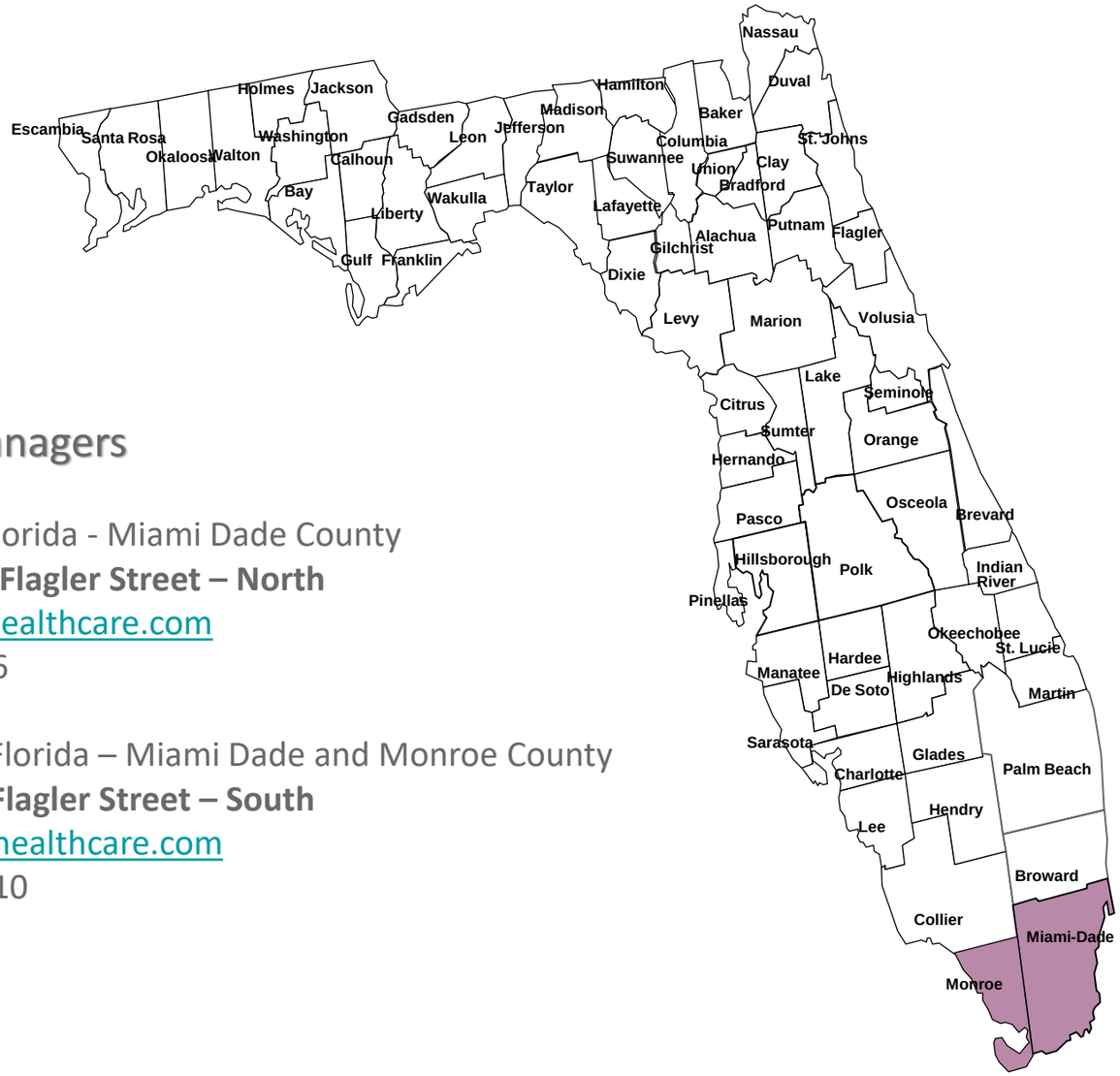
The Molina Healthcare Provider Engagement team offers its delegates training to guarantee continuous, comprehensive education on the operational requirements and processes of the Molina Healthcare provider network. Additionally, this training ensures compliance with relevant standards and regulatory requirements.

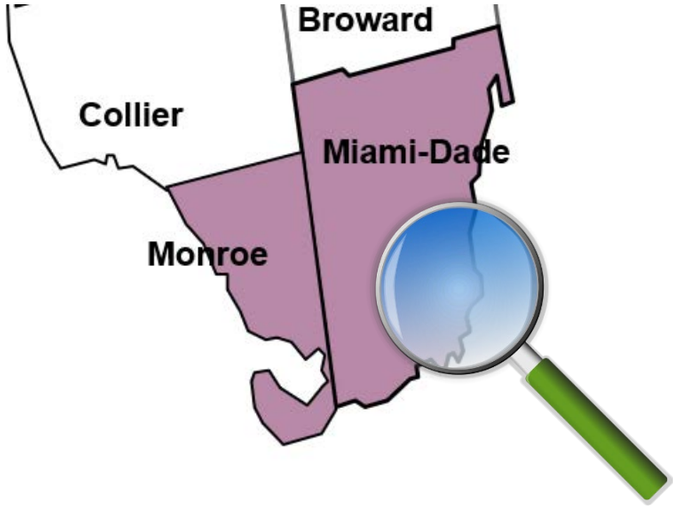
Additional in-services will be conducted monthly to support ongoing education, with training available upon request (e.g., annually, quarterly, monthly, or as needed).

Provider Engagement Team Support

- As a contracted provider with Molina, you are crucial in delivering quality care to our members. We value our partnership.
- We welcome your feedback and look forward to helping you in your efforts to provide excellent care for our members.
- As the Provider Engagement team, we support your office. We can provide training, conduct in-person or virtual visits, assist with Provider Portal registration, answer your questions, and serve as your primary contact for all provider needs.
- Get to know your Provider Services Manager: Provider Service Manager per FL Regions

Provider Services Managers





Provider Service Managers

Samantha Diaz – South Florida - Miami Dade County
Region: I (formerly 11) / Flagler Street – North
Samantha.Diaz@molinahealthcare.com
Cell Phone: 786-778-6906

Vanessa Crespo – South Florida – Miami Dade and Monroe County
Region I (formerly 11) / Flagler Street – South
Vanessa.Crespo@molinahealthcare.com
Cell Phone: (786) 918-6310

Behavior Analysis (BA)

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Description

Behavior analysis (BA) services are highly structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.

Coverage and Limitations

We cover recipients under the age of 21 years requiring medically necessary services.

Is Prior-Auth Required?

Yes. Refer to the Prior Authorization Code Lookup Tool on our website for requirements: MolinaHealthcare.com/providers/fl/medicaid/home.aspx.

Important Links

Medicaid Fee Schedule	Rule 59G-4.002, Provider Reimbursement Schedules and Billing Codes | Florida Agency for Health Care Administration (myflorida.com)
Behavior Analysis Services Information – AHCA	Behavior Analysis Services Information | Florida Agency for Health Care Administration (myflorida.com)
Molina Healthcare Provider Manual	Provider Manual and Orientation (molinahealthcare.com)

AHCA Medicaid Fee Schedule

BA.Fee.Schedule.10012024.xlsx

Behavior Analysis Fee Schedule October 1, 2024

Service Description	Procedure Code	Mod	Maximum Fee	Reimbursement and Service Limitations
Behavior identification - assessment	97151		$19.05 per 15 minutes	Medicaid reimburses a maximum of 24 units per behavior assessment
Behavior identification - supporting assessment	97152		$12.19 per 15 minutes	Medicaid reimburses a maximum of 8 units per behavior assessment
Assessment add-on practitioner	0362T		$12.19 per 15 minutes	Medicaid reimburses a maximum of 16 units for an initial behavior assessment or reassessment; need must be prior authorized and determined to be medically necessary
Behavior Reassessment	97151	TS	$19.05 per 15 minutes	Medicaid reimburses a maximum of 18 units for a behavior reassessment
Behavior treatment with protocol modification	97155		$19.17 per 15 minutes	Service provided by a Lead Analyst
Behavior treatment with protocol modification	97155	HN	$15.37 per 15 minutes	Service provided by an assistant behavior analyst (BCaBA)
Behavior treatment with protocol modification, under concurrent supervision, per 15 minutes, non-reimbursable	97155	XP	Not reimbursed	Supervisee only, supervisor may be reimbursed using 97155 or 97155HN
Behavior treatment by protocol	97153		$12.26 per 15 minutes	Service provided by a Registered Behavior Technician (RBT), a BCaBA, or a Lead Analyst
Behavior treatment by protocol, under concurrent supervision, per 15 minutes, non-reimbursable	97153	XP	Not reimbursed	Supervisee only, supervisor may be reimbursed using 97153, 97155 or 97155HN
Treatment add-on practitioner	0373T		$12.19 per 15 minutes	Need must be prior authorized and determined to be medically necessary
Family training by Lead Analyst	97156		$19.05 per 15 minutes	Service provided by a Lead Analyst
Family training via telemedicine	97156	GT	$19.05 per 15 minutes	Service provided by a Lead Analyst; Florida Medicaid reimburses up to 2 hours per week
Family training by assistant	97156	HN	$15.24 per 15 minutes	Service performed by a BCaBA
Group BA services by protocol, two clients in group	97154	UN	$7.58 per 15 minutes	Maximum 6 clients per group, service provided by Lead Analyst, BCaBA, or RBT

AHCA Medicaid Fee Schedule – Continued

Group BA services protocol, three clients in group	97154	UP	$7.08 per 15 minutes	Maximum 6 clients per group, service provided by Lead Analyst, BCaBA, or RBT
Group BA services by protocol, four clients in group	97154	UQ	$6.58 per 15 minutes	Maximum 6 clients per group, service provided by Lead Analyst, BCaBA, or RBT
Group BA services by protocol, five clients in group	97154	UR	$6.08 per 15 minutes	Maximum 6 clients per group, service provided by Lead Analyst, BCaBA, or RBT
Group BA services by protocol, six clients in group	97154	US	$5.58 per 15 minutes	Maximum 6 clients per group, service provided by Lead Analyst, BCaBA, or RBT
Group BA services with protocol modification, two clients in group	97158	UN	$9.58 per 15 minutes	Maximum 6 clients per group, service provided by Lead Analyst or BCaBA
Group BA services with protocol modification, three clients in group	97158	UP	$9.08 per 15 minutes	Maximum 6 clients per group, service provided by Lead Analyst or BCaBA
Group BA services with protocol modification, four clients in group	97158	UQ	$8.58 per 15 minutes	Maximum 6 clients per group, service provided by Lead Analyst or BCaBA
Group BA services with protocol modification, five clients in group	97158	UR	$8.08 per 15 minutes	Maximum 6 clients per group, service provided by Lead Analyst or BCaBA
Group BA services with protocol modification, six clients in group	97158	US	$7.58 per 15 minutes	Maximum 6 clients per group, service provided by Lead Analyst or BCaBA

NOTE: One BA practitioner's services are reimbursable when concurrent services are provided by more than one BA practitioner, unless determined to be medically necessary, prior authorized, and indicated in the approved behavior plan.

Claims

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Submitting Claims to Molina

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

Paper Claims can be submitted here:

Molina Healthcare Inc PO BOX 22812
Long Beach, CA 90801

Electronic Claims Submission:

We encourage all Providers to submit their claims through our Availity portal
Availity Essentials Portal Link: Availity Essentials Portal

Submit Claims to Molina through your EDI clearinghouse using:

- Payer ID: 51062

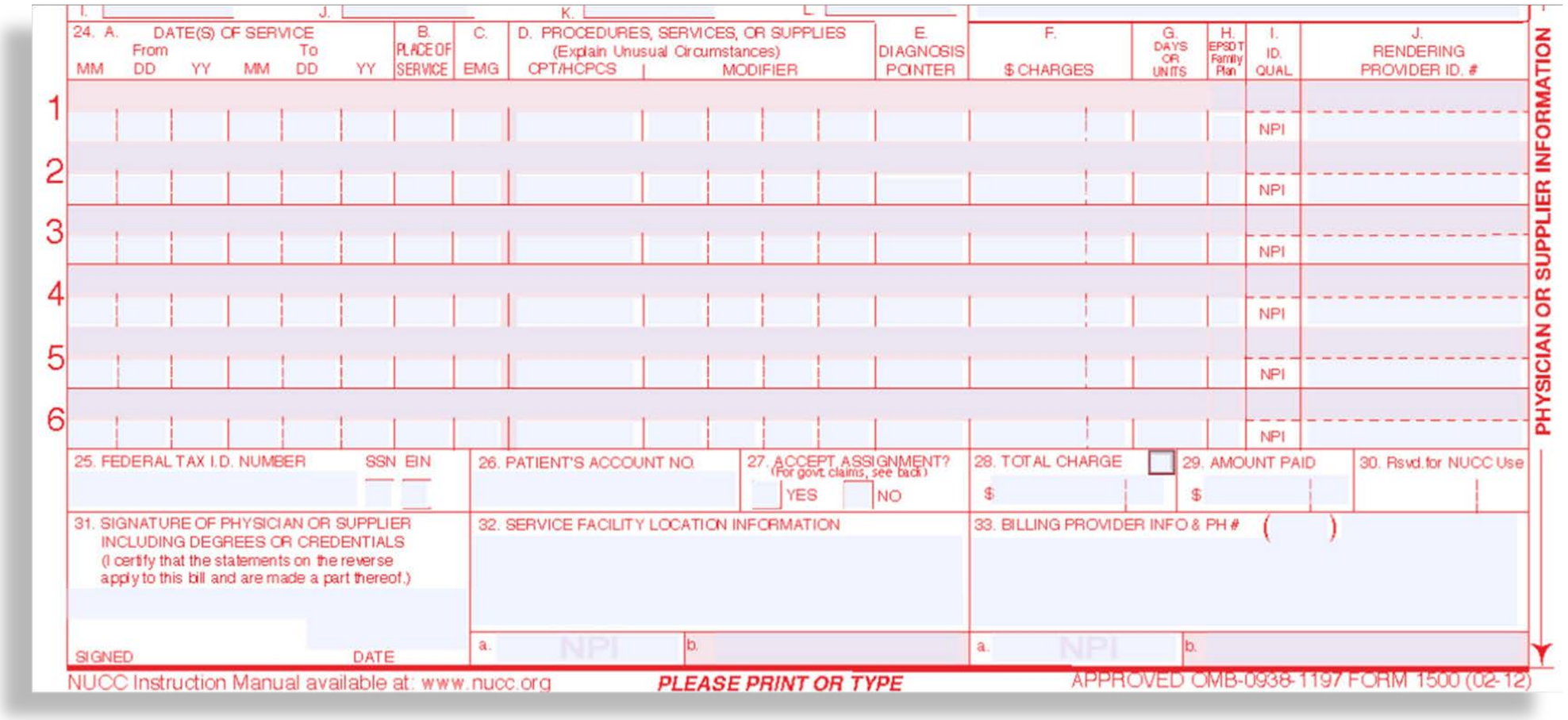
ERA/EFT

For ERA/EFT registration, please visit our Molina website: Enrollment Information for ERA/EFT
Any questions during this process should be directed to ECHO Health
(888) 834-3511 or edi@echohealthinc.com.

Claim Form

Professional CMS 1500

CMS HCFA 1500
Claim Form-Fillable.



Units

- Providers must only bill for services performed for 8 minutes or more when determining the number of billable 15-minute units. For services that exceed 15 minutes, providers must use the total minutes of service provided and divide by 15 to obtain the number of units.
- Remaining minutes of service greater than or equal to 8 minutes count as one unit and may be billed as such. Remaining minutes less than 8 do not count as a unit and are not billable.

BA Services	1 hour	2 hours	3 hours	4 hours	5 hours
# of units	4	8	12	16	20

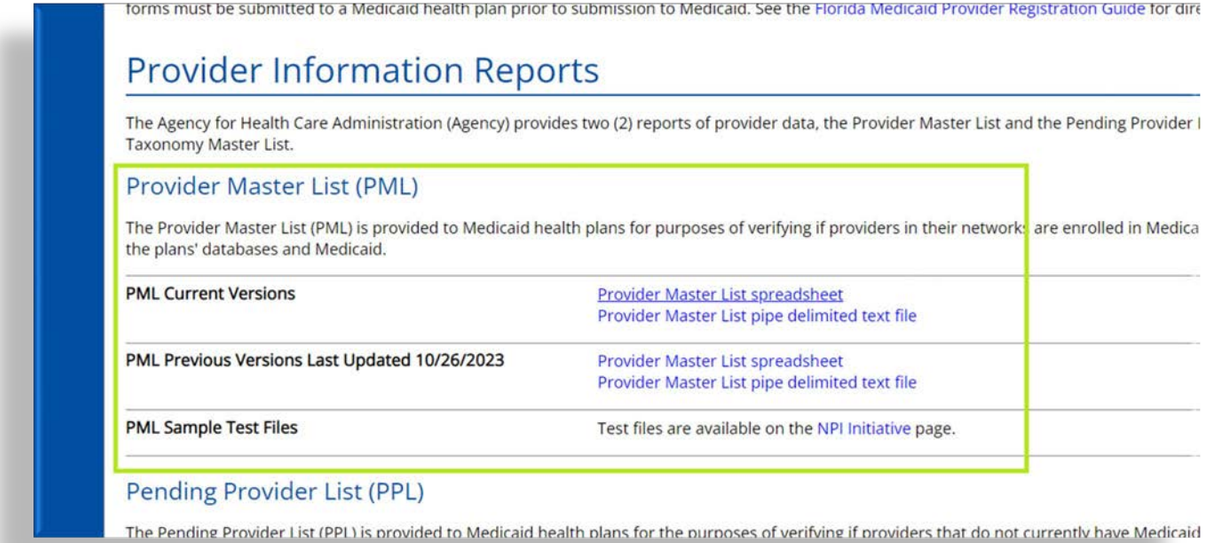
For services that exceed 15 minutes, providers must use the total minutes of service provided and divide by 15 to obtain the number of units.

Example: 30 minutes divided by 15 = 2 units

Health Plan Expectations

- Use the most current and appropriate billing codes, modifiers, and units as incorporated by reference in Rule 59G-4.002, F.A.C.
- All providers must be fully enrolled with AHCA prior to rendering services for Medicaid recipients
- Prior Authorizations are requested timely
- Supervision: Florida Medicaid requires supervision of BCaBAs and RBTs in accordance with certification board requirements and specified in the supervision plan of the approved behavior plan
- Effective May 2023, it became a requirement that providers must be registered in PML with the corresponding taxonomy code. Claims must be submitted to the plan with the taxonomy that matches PML.

Link to PML: [Registration | Florida Medicaid Web Portal]


forms must be submitted to a Medicaid health plan prior to submission to Medicaid. See the Florida Medicaid Provider Registration Guide for dire

Provider Information Reports

The Agency for Health Care Administration (Agency) provides two (2) reports of provider data, the Provider Master List and the Pending Provider I
Taxonomy Master List.

Provider Master List (PML)

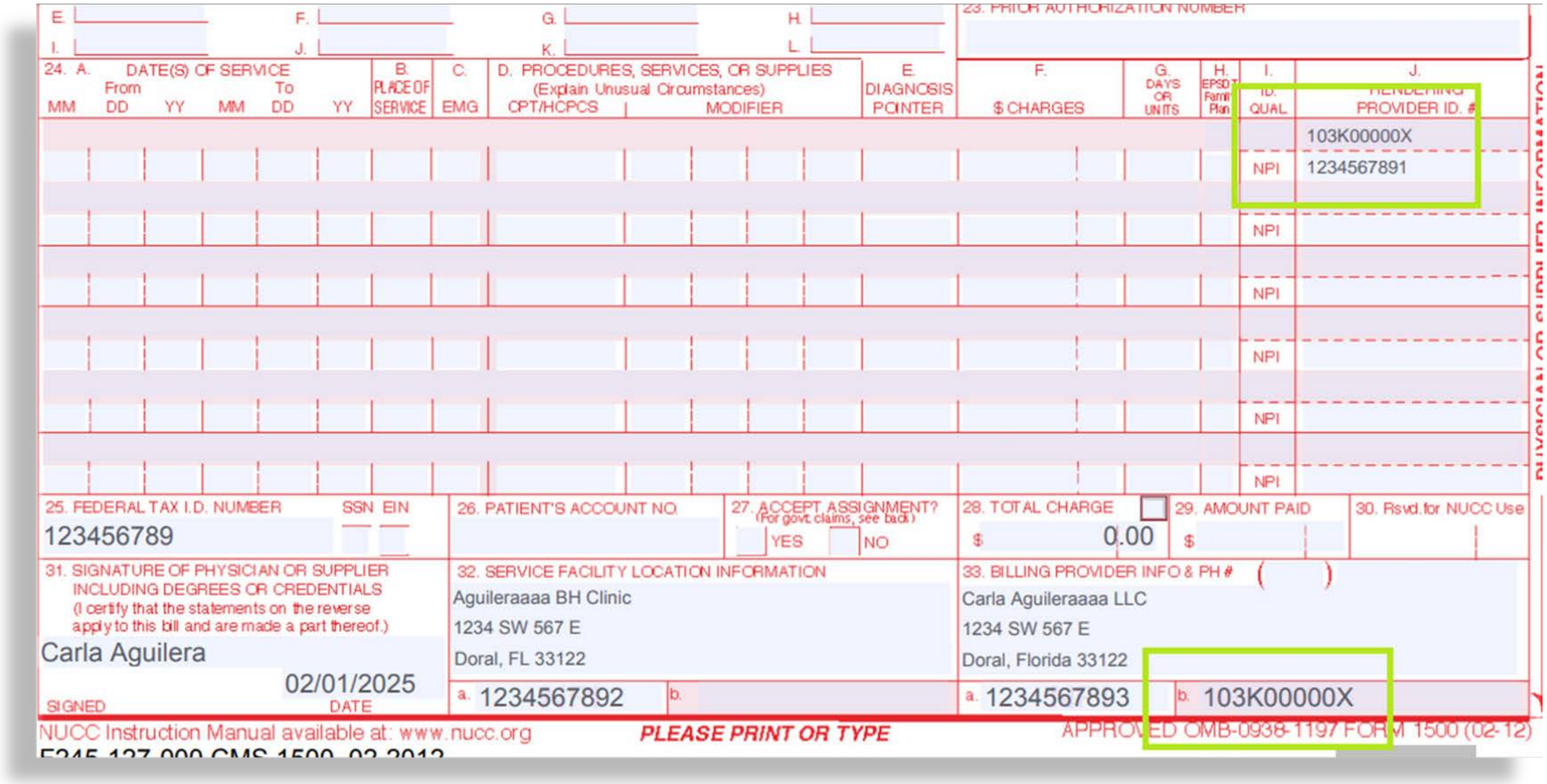
The Provider Master List (PML) is provided to Medicaid health plans for purposes of verifying if providers in their network: are enrolled in Medica
the plans' databases and Medicaid.

PML Current Versions	Provider Master List spreadsheet Provider Master List pipe delimited text file
PML Previous Versions Last Updated 10/26/2023	Provider Master List spreadsheet Provider Master List pipe delimited text file
PML Sample Test Files	Test files are available on the NPI Initiative page.

Pending Provider List (PPL)

The Pending Provider List (PPL) is provided to Medicaid health plans for the purposes of verifying if providers that do not currently have Medicaid

Taxonomy Codes



Place of Service Codes

POS Code	POS Name	POS Description
02	Telehealth Provided Other than in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology. (Effective January 1, 2017) (Description change effective January 1, 2022, and applicable for Medicare April 1, 2022.)
03	School	A school facility where a recipient receives a Medicaid service.
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, intermediate care facility (ICF), or mobile van where the health professional routinely provides health examination, diagnosis and treatment of illness or injury on an ambulatory basis
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
99	Other place of Service	Other place of service not identified above.

For a list of additional POS codes, feel free to contact us directly.

Claim Submission

- We encourage all Providers to submit their claims through our Availity portal

- Availity Essentials Portal: provider.molinahealthcare.com

Availity Essentials portal Claims submission benefits :

• Ability to add attachments to Claims	• Check Claims status
• Submit corrected Claims	• Receive timely notification of a change in status for a particular Claim
• Easily and quickly void Claims	• Ability to Save incomplete/un-submitted Claims
• Create/Manage Claim Templates	

Claim Submission

Electronic Claims submission provides significant benefits to the Provider including:

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

Timely Filling

Clean Claim Timely Filling	Six months after the discharge for inpatient services or the Date of Service for outpatient services

Telehealth

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Telehealth Services

- Members can receive physical and behavioral health services from Participating Providers via Telehealth and Telemedicine.
- The following additional provisions apply to the use of Telehealth and Telemedicine services:

  - Telemedicine services provided under Florida Medicaid must be performed by licensed practitioners within their scope of practice.

  - Telemedicine services must involve the use of interactive telecommunications equipment which includes, at a minimum, audio and video equipment permitting two-way, real-time communication between the enrollee and the practitioner; and Telephone conversations, chart review, electronic mail messages, or facsimile transmissions are not considered telemedicine.

Telehealth Services

Telehealth/Telemedicine Providers: Telehealth transmissions are subject to HIPAA-related requirements outlined under State and Federal Law, including:

- 42 C.F.R. Part 2 Regulations
- Health Information Technology for Economic and Clinical Health Act (HITECH Act)

All records shall contain documentation to include the following items for services provided through telemedicine:

(1) A brief explanation of the use of telemedicine in each progress note;
(2) Documentation of telemedicine equipment used for the particular covered services provided; and
(3) A signed statement from the enrollee or the enrollee's authorized representative indicating their choice to receive services through telemedicine. This statement may be for a set period of treatment or one-time visit, as applicable to the service(s) provided.

Medicaid does not reimburse for the costs or fees of any equipment necessary to provide services through telemedicine, including telecommunication equipment and services. The enrollee has a choice of whether to access services through a face-to-face or telemedicine encounter.

The Telehealth Attestation can be found on Molina's website: MolinaHealthcare.com/Providers/FL/Medicaid/Forms/FUF.aspx

Availity Portal

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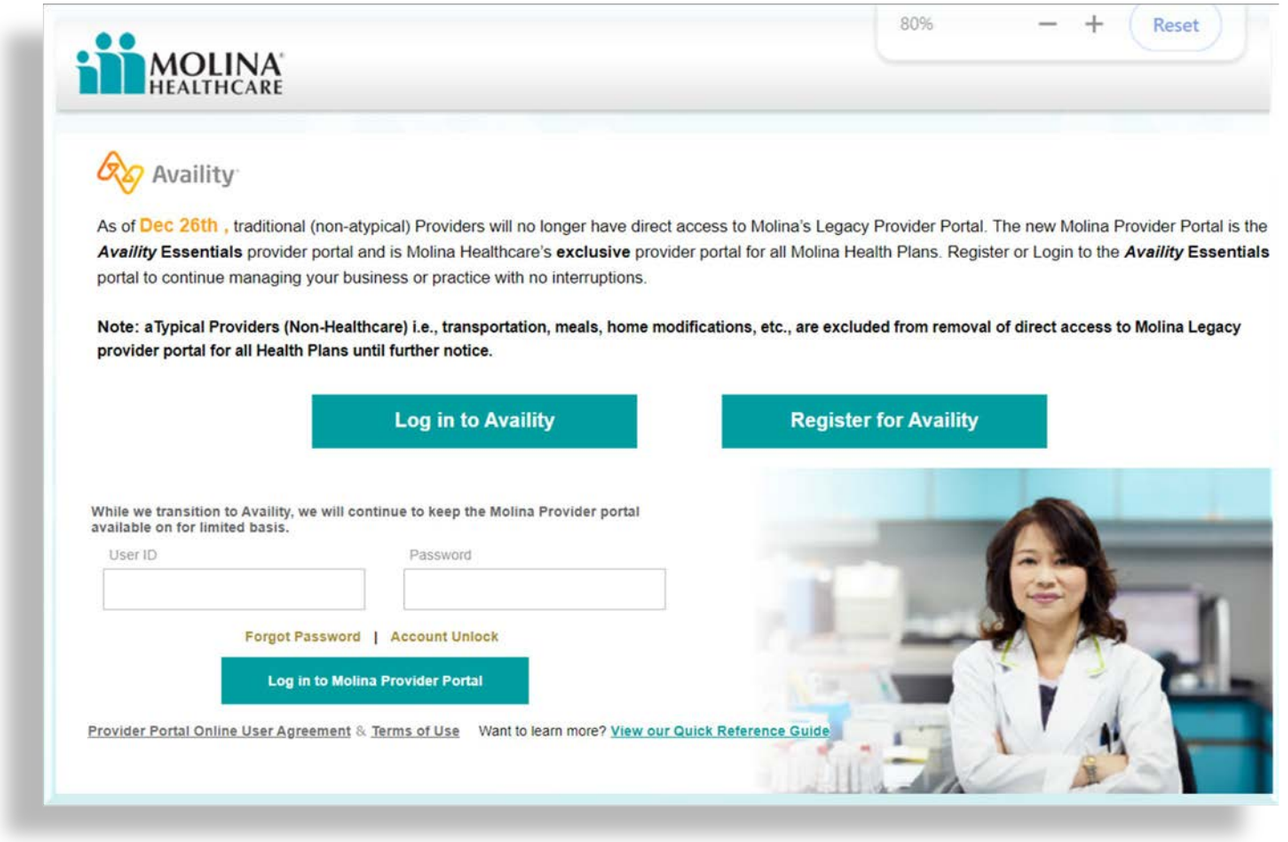
Availity Registration and Login

- Availity Essentials Portal: provider.molinahealthcare.com



Availity Tools

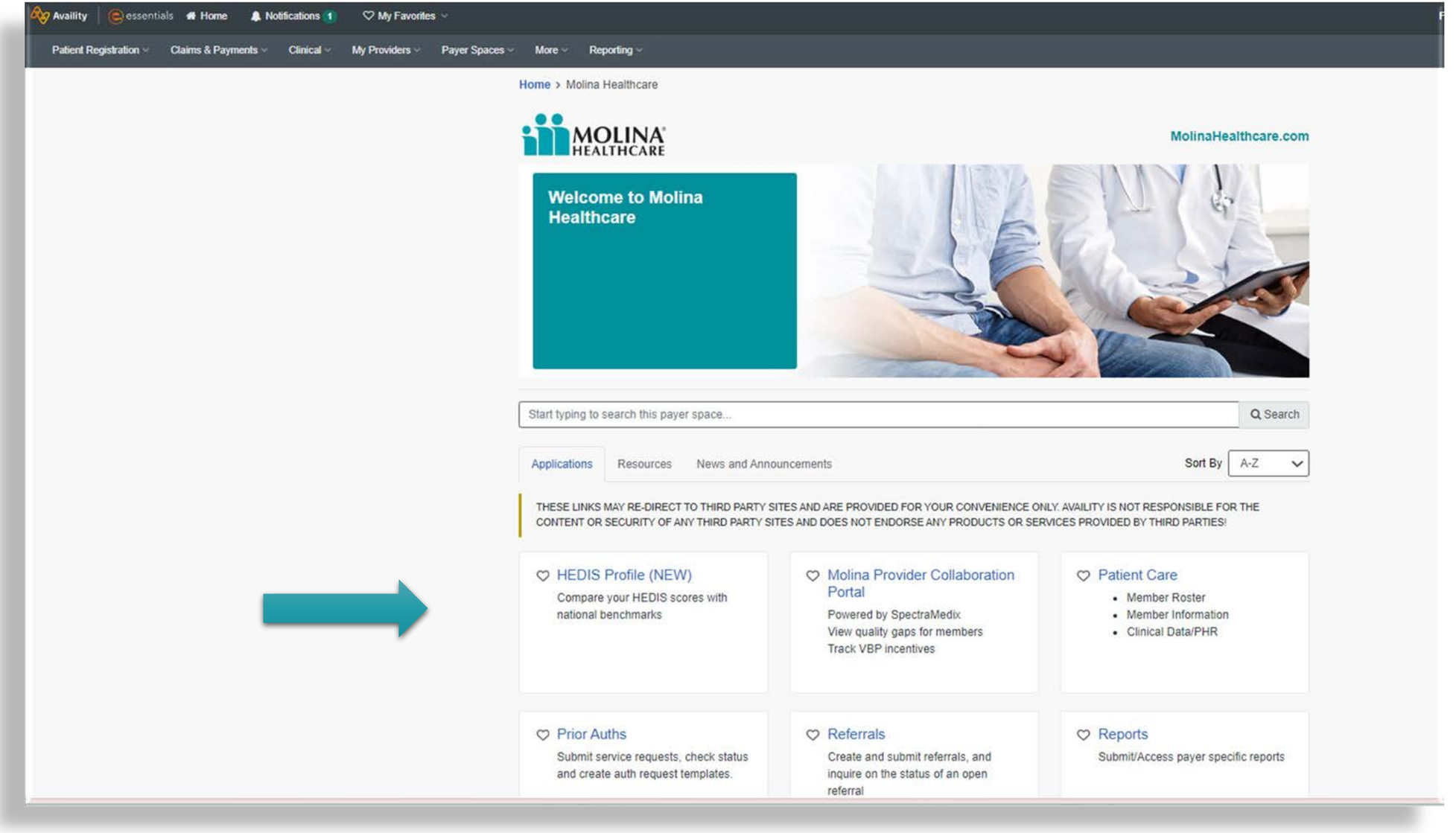
Providers and third-party billers can use the no cost Availity Essentials portal to perform many functions online without the need to call or fax Molina. Registration can be performed online and once completed the easy-to-use tool offers the following features:

- Verify Member eligibility, covered services and view HEDIS needed services (gaps)
- Claims:
  - Submit Professional (CMS1500) and Institutional (UB04) Claims with attached files
  - Correct/Void Claims
  - Add attachments to previously submitted Claims
  - Check Claims status
  - View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
  - Create and manage Claim Templates
  - Create and submit a Claim Appeal with attached files

Availity Tools - Continued

- Prior Authorizations/Service Requests
  - Create and submit Prior Authorization/Service Requests
  - Check status of Authorization/Service Requests
- Download forms and documents
- Send/receive secure messages to/from Molina

Availity Tools Visual



BA Specialty Type, Taxonomy and Registration

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AHCA Provider Enrollment

- To provide BA services, providers must be registered with AHCA

- For new providers, visit the AHCA website for enrollment requirements using the following link

New Medicaid Providers | Florida Medicaid Web Portal (flmmis.com)

Specialty Registration Overview

Provider Specialty Code:

390 Registered Behavior Technician (RBT)

391 Assistant Behavior Analyst

392 Lead Analyst

Provider Type Code: 39

For a full list visit the AHCA website using the following link: Provider_Type_and_Specialty_List.pdf (flmmis.com)

Behavior Analyst Taxonomy Code

Provider Specialty: Behavior Analyst

Provider Taxonomy: 103K00000X

Provider Specialty: Assistant Behavior Analyst

Provider Taxonomy: 106E00000X

Provider Specialty: Behavior Technician

Provider Taxonomy: 106S00000X

Credentialing

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Credentialing Process

- Credentialing is required for Behavior Analysts providers
  - **103K00000X - Behavior Analyst / Specialty code 392 - Lead Analyst**
- Providers must complete Molina's credentialing application that is located on our Molina website. This will be used for credentialing and loading of provider's information

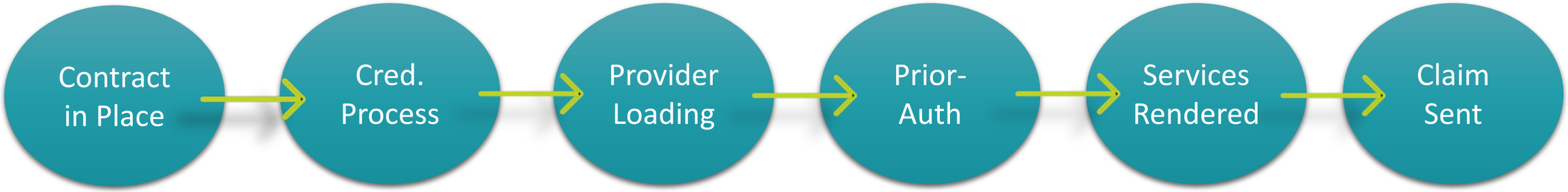
  Link: Frequently Used Forms (molinahealthcare.com)
- Once the application is complete, you will submit the request to the provider engagement team mailbox with a CMS 1500 claim sample form and a W-9 form. W-9 form must be signed and dated. Date cannot exceed 1 year at the time from submission.

  Mailbox: MFLProviderServicesManagement@MolinaHealthCare.Com

The credentialing process can take up to 60 days for clean applications. Make sure the provider's CAQH is active with most recent information.

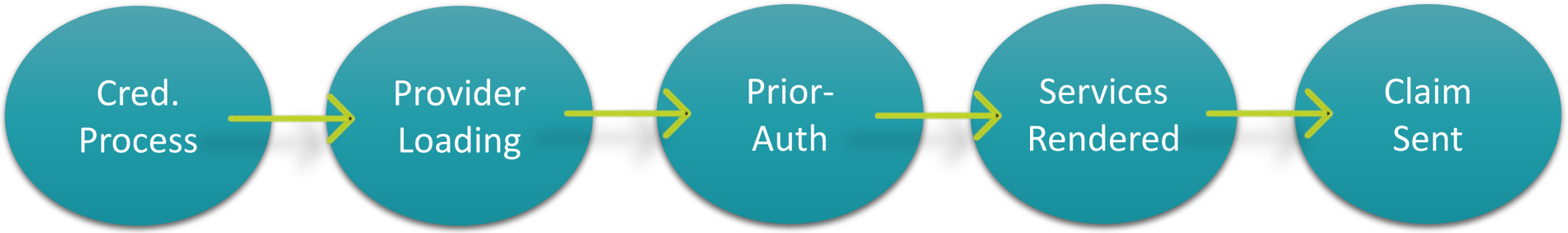
- Once the provider passes the credentialing process, a letter is sent with the approval date
- The approval date is the effective date for the provider to start seeing members

Provider Onboarding – New Contract



For all new providers, training will be conducted within 30 days upon completion of the credentialing process

Provider Onboarding – Existing Contract



Authorizations

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Submitting a Prior-Auth

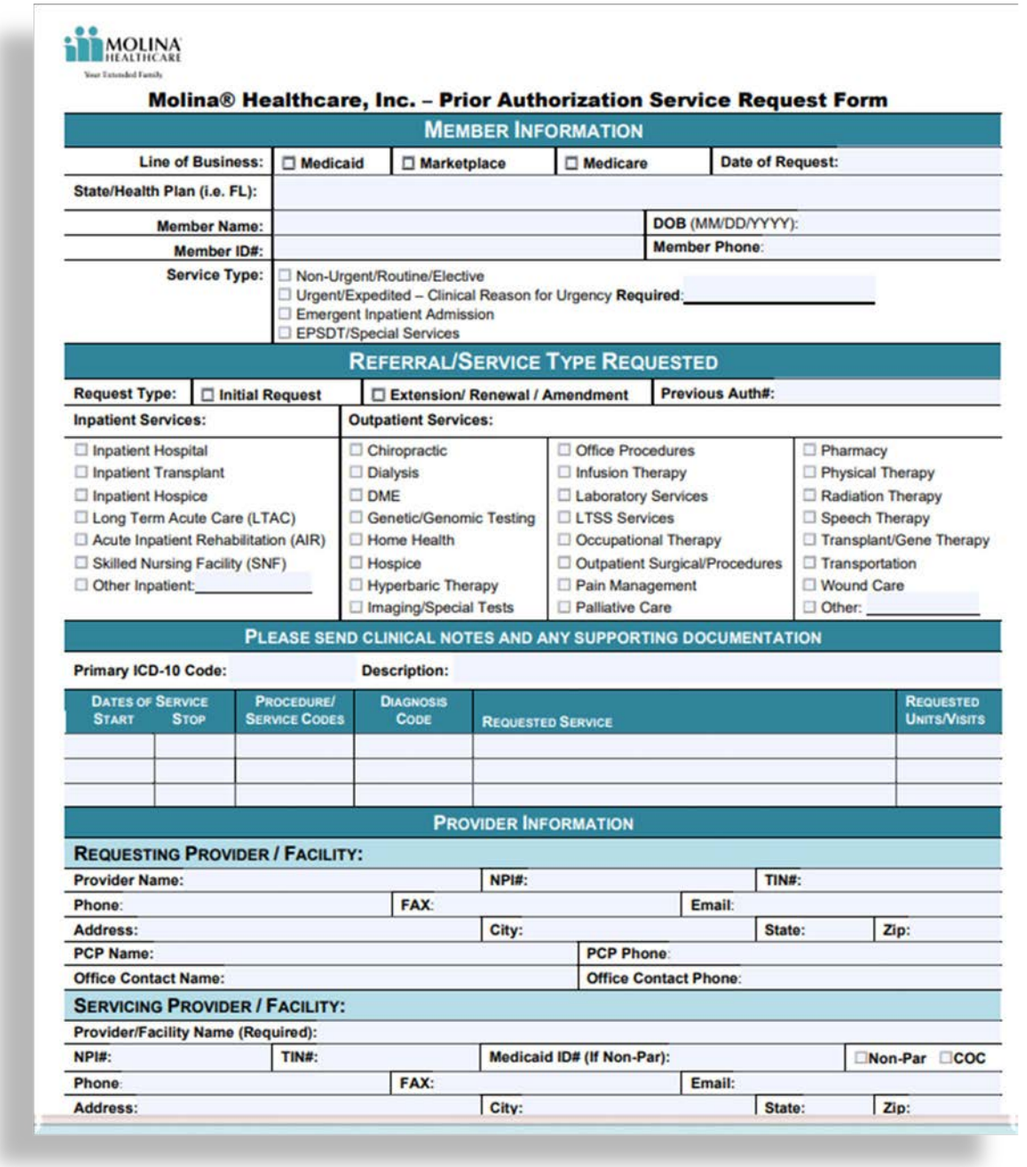
- Providers can submit prior-authorization request via fax to (**866) 440-9791**
- We will have a designated contact over in Health Care Services managing request for BA services

- Providers can submit a prior-authorization request via Availity Essentials Provider Portal

Prior-Auth Form

- Providers can obtain a prior auth form by visiting our Forms page on the Molina website:

[Frequently Used Forms (molinahealthcare.com)]



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Your Extended Family

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

MEMBER INFORMATION

Line of Business:	☐ Medicaid	☐ Marketplace	☐ Medicare	Date of Request:
State/Health Plan (i.e. FL):				
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/Genomic 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:	

Prior-Authorizations Requests – BA Services

- Providers are sent to Molina Healthcare of Florida's Utilization Management department by e-portal or fax at (**866) 440-9791.**
- A Molina Prior Authorization Form (Molina's website Frequently Used Forms) is to be completed and submitted along with clinical information required to assess medical necessity.
- An authorization is required prior to the initiation of BA services and at least every 180 days thereafter. Providers may request authorization more frequently upon a change in the recipient's condition requiring an increase or decrease in services.
- Providers must request a new authorization if clinical conditions require a new assessment.
- Initial Authorization: Prior authorization is required. Providers are to submit request at least 4 days before services are initiated.
- Continued stay (reauthorization) review: Prior authorization is required. Providers are to submit the request no less than 10 days, but no more than 30 business days before the end of the current approval period. Requests for 97151TS (Reassessments) from the current provider should be entered as a continued stay.
- Modification review: Authorization is required if a change in the recipient's clinical status requires an increase in the previously approved services. Providers are to submit the request as soon as the need is identified, and all required supporting documentation is obtained.

Prior-Authorizations Requests – BA Services Continued

- Authorization requests for services to be delivered in a school must include the recipient's Individualized Education Plan (IEP). In the absence of an IEP, or when an IEP does not include BA services, the provider must include documentation providing justification for the services requested and an estimated timeframe of when an IEP will be completed or updated. If a school does not conduct IEPs, a 504 plan may be submitted in its place. If a school does not provide either, the provider must include documentation that includes the name of the school and an explanation that neither plan is available.

- Authorization requests must include assessment findings.

- Authorization requests for service continuation must include data about parental guardian participation in services.

- Assessment and Behavior Plan for Reauthorization and Continuation of Services:

  - Subsequent assessments and behavior plans for reauthorization and continuation of services must include:
  - Data reflecting progress of all behaviors targeted for improvement. Each behavior under treatment must have its own data table and corresponding graph.
  - A narrative discussion of progress and a statement of justification for continuation of care at the intensity level requested.
  - If significant clinical progress is not made over the course of an authorization period, the provider must explain why clinically significant progress was not made and treatment changes to promote progress.

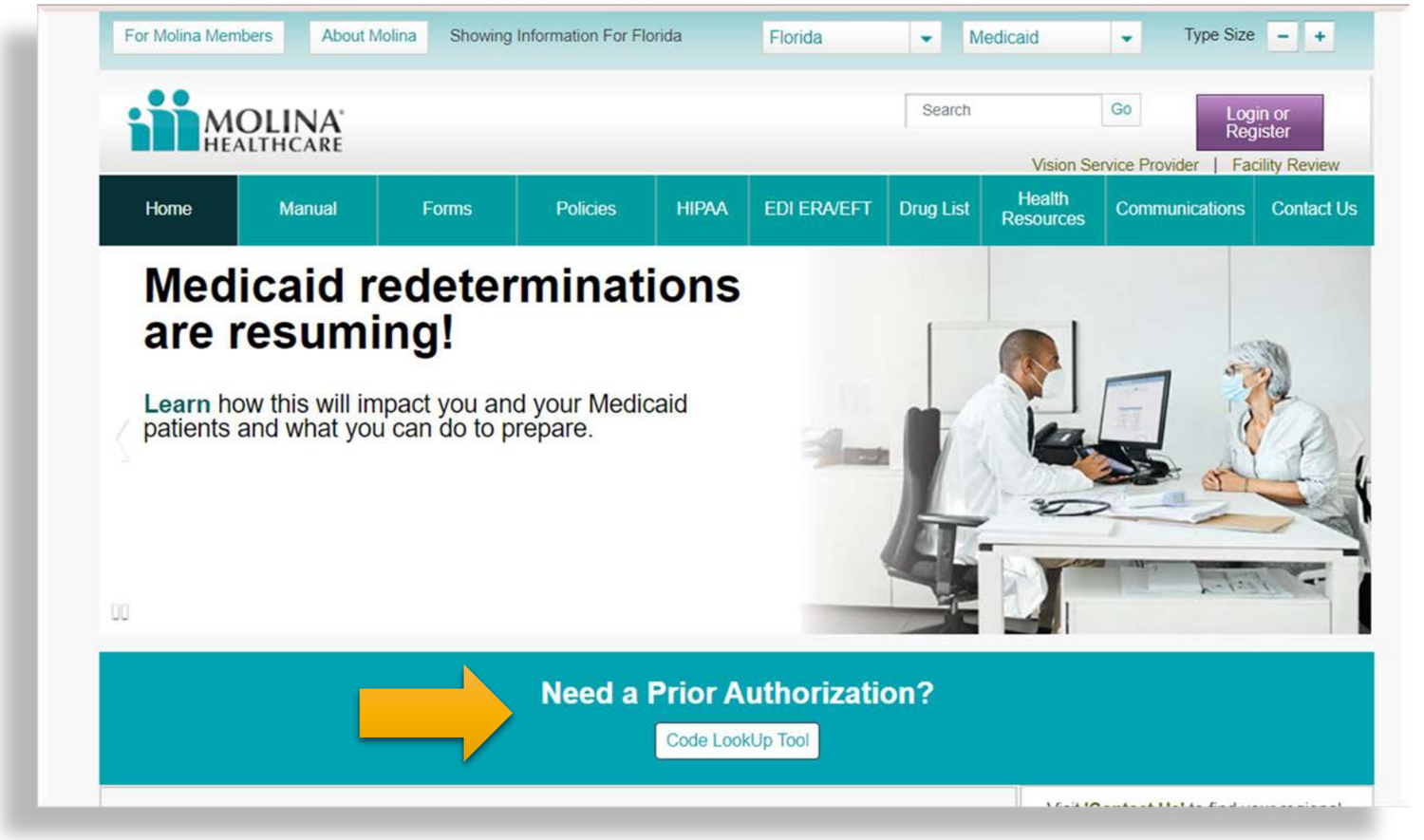
Prior-Authorizations Requests – BA Services Continued

- Approved requests are sent back to the provider via fax or by phone and will include the authorization number and the dates of service (DOS) authorized.
- Cases that do not appear to meet medical necessity criteria are required to be reviewed by a physician/CMO/BH Medical Director. Determinations resulting in a denial or reduction are made only by the Medical Director or physician designee.
- This information is shared on our website for you to refer at any time

Prior-Auth Look up Tool

- You can look up any CPT code to check if it requires prior authorization

[Florida Providers Home (molinahealthcare.com)]



Continuity of Care (COC)

MOLINA® HEALTHCARE

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Continuity of Care

Molina Healthcare will honor a 120-day continuity of care (COC) period during which all approved prior authorizations for services will be honored, and providers will be reimbursed for services provided on or after 2/1/2025. Molina Healthcare will also honor prior authorizations for behavior analysis services for a minimum of 120 days, extending any expiring authorizations for the remainder of the COC period. Non-participating providers will be reimbursed at the rate they received prior to the enrollee's transition for 90 days. For enrollees changing plans during the COC period, Molina Healthcare will coordinate with the previous plan to ensure existing authorizations are honored.

Requests for continued care should be submitted to the Utilization Management Department at:

Phone: (855) 322-4076

Fax: (866) 440-9791

Continuity of Care may not apply if a provider is terminated for cause.

Data Management & Provider Online Directory (POD)

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Provider Data Accuracy and Validation

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

In accordance with the terms specified in your Provider Agreement, Providers must notify Molina of any changes as soon as possible but at a minimum of 30 calendar days in advance of any changes in any Provider information on file with Molina. Changes include, but are not limited to:

- Change in office location(s)/address, office hours, phone, fax, or email
- Addition or closure of office location(s)
- Addition of a Provider (within an existing clinic/practice)
- Change in Provider or practice name, Tax ID and/or National Provider Identifier (NPI)
- Opening or closing your practice to new patients (PCPs only)
- Change in specialty
- Any other information that may impact Member access to care

Provider Data Accuracy and Validation

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

- Please visit our Provider Online Directory at MolinaHealthcare.com to validate your information.
- Providers can make updates through the MFLProviderServicesManagement@MolinaHealthcare.com mailbox, or you may submit a full roster that includes the required information above for each healthcare Provider and/or healthcare facility in your practice.
- Molina is required to audit and validate our Provider Network data and Provider Directories routinely. As part of our validation efforts, we may reach out to our Network of Providers through various methods, such as letters, phone campaigns, face-to-face contact, fax and fax-back verification, etc. Molina also may use a vendor to conduct routine outreach to validate data that impacts the Provider Directory or otherwise impacts membership or ability to coordinate Member care. Providers are required to supply timely responses to such communications.

Provider Disputes & Appeals

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Provider Disputes & Appeals

- Molina is committed to the timely resolution of all provider complaints. Any disagreement regarding the processing, payment or non-payment of a claim is considered a Provider Dispute.

- Provider disputes are typically disputes related to overpayment, underpayments, untimely filing, missing documents (i.e., consent forms, primary carrier explanation of benefits) and bundling issues. Provider Appeals are requests related to a denial of an authorization or medical criteria.

- Providers disputing a Claim previously adjudicated must request such action within one year of Molina's original remittance advice date. A written acknowledgment letter will be mailed within three business days of receipt of a claim dispute or appeal. In addition, a written notice of the status of your request will be mailed every 30 days and thereafter until the case is resolved. Providers will be notified of Molina's decision in writing within 60 days of receipt of the claim dispute or appeal in accordance with 641.3155, F.S.

Appeals & Grievances

Molina has a dedicated staff for providers available to receive and resolve claim disputes and appeals. Molina offers the following submission options:

- Submit requests directly to Molina Healthcare of Florida via the Availity Essentials portal: provider.MolinaHealthcare.com.
- Submit requests directly to Molina Healthcare of Florida via fax at: 877-553-6504
- Submit Provider Disputes impacting more than 10 claims can be submitted via email to MFLClaimsDisputesProjects@MolinaHealthcare.com
- Submit Provider Appeal request to MFL_ProviderAppeals@MolinaHealthcare.com
- Submit Provider Disputes through the Contact Center at 866-472-4585 (Monday – Friday, 8am – 7pm)
- Submit requests via mail to:

Molina Healthcare of Florida
Appeal and Grievance Unit
P.O Box 36030
Louisville, KY 40233-6030

Provider Dispute/Appeal Form → Provider Dispute/Appeal Form (molinahealthcare.com)

Fraud, Waste, and Abuse

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Fraud, Waste and Abuse

Federal and state resources dedicated to the prevention and detection of health care fraud have increased substantially in the past few years as part of the effort to control federal program expenditures. Molina is committed to working with federal and state regulatory and law enforcement agencies to help prevent and detect fraud, and to recover funds paid for fraudulent claims.

Fraud, Waste and Abuse

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

Fraud, Waste and Abuse

	State	Federal
Abuse	Means provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care. (409.913 F.S.)	Means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. (42 CFR 455.2)
Fraud	Means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law. (409.913 F.S.)	Means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR 455.2).
Overpayment	Includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake. (409.913 F.S.)	N/A
Waste	Means health care spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs to the Medicaid program.	N/A

Fraud, Waste and Abuse

- We offer you the following options to report suspicion of fraud, waste, and abuse or instances of non-compliance. You have the right to report your concerns anonymously and without fear of retaliation.
- You may report suspected cases of fraud and abuse to Molina's Alert Line at (866) 606-3889. MolinaHealthcare.AlertLine.com
- To submit written report to Molina Healthcare of Florida via mail or fax:

Compliance Officer

Molina Healthcare of Florida

8300 NW 33rd St, Suite 400

Doral, Florida 33122

Confidential Fax: (866) 440-8591 You may also report directly to the Florida Medicaid Consumer Complaint Hotline at (888) 419-3456. Apps.AHCA.MyFlorida.com/InspectorGeneral/fraud_complaintform.aspx

Provider Online Resources

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Provider Online Resources

Our Molina Healthcare of Florida website offers a variety of tools and resources for our Providers.

Florida Providers Home (molinahealthcare.com)

Item	Link
Frequently Used Forms	Frequently Used Forms (molinahealthcare.com)
Provider Newsletter	Molina FL Provider Newsletters (molinahealthcare.com)
Resources & Training	Resources & Training (molinahealthcare.com)
You Matter to Molina	You Matter to Molina (molinahealthcare.com)
Service Area Representatives	Service Area (molinahealthcare.com)
Live Issue Resolution (download contact list)	Have a Concern, Issue or Escalation? (molinahealthcare.com)

Recap

- Molina Healthcare is a Health Maintenance Organization that offers health care services for individuals with government-sponsored health care.
- Molina was awarded Medicaid in region I (formerly region 11) effective 02/01/2025 for Miami-Dade and Monroe County
- Visit AHCA website for BA fee schedule and PML file
- Submit claims to Molina via Availity Portal
- Availity Portal is a great tool available for providers to submit claims, referrals, prior authorization, and check member eligibility
- BA services can be provided via telehealth. Make sure guidelines for telehealth services are followed
- Providers are to be registered with AHCA directly prior to rendering services to Medicaid members. Ensure Medicaid ID tied to pay-to and rendering NPI. Compare Taxonomy in PML with what is being provided in CMS1500 claim form.
- Prior to rendering services, a prior-authorization is required. You can submit via fax or via Availity Essentials portal

Recap

- COC period is good for 120 days for ABA services. There will be no interruption in member's care
- Ensure demographic updates or request to load a new provider is sent to the plan with enough time for processing
- Follow our formal appeals and disputes process. You can submit a dispute via call center, via email or through mail disputes mailbox if applicable
- All providers must complete the required credentialing application. This form is available on our website under frequently used forms. Only the Behavior Analyst requires credentialing. We still need the app for providers who don't require credentialing as the form will be used to load the information in the system. Forms to be sent to MFLProviderServicesManagement@MolinaHealthCare.Com
- Fraud, Waste and Abuse: Molina is committed to working with federal and state regulatory and law enforcement agencies to help prevent and detect fraud, and to recover funds paid for fraudulent claims.
- Online resources and communications are available on our website, please ensure you visit our website often for news and updates.
- Refer to our territory map for assigned Provider Services managers in Region I. We are here to support your office with any concerns, questions or assistance that is needed.

Questions?

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