Texas Medicare-Medicaid Program

Nursing Facility Provider Orientation

Molina Healthcare of Texas – Nursing Facility Provider Services

June 2015

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MHTMMPNF_PRV_070215

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Our Story & Who We Are

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 30 years.

Mission Statement

Our mission is to provide quality health services to financially vulnerable families and individuals covered by government programs

Vision Statement

Molina Healthcare is an innovative national health care leader, providing quality care and accessible services in an efficient and caring manner

Core Values

*We strive to be an exemplary organization:*

1. We care about the people we serve and advocate on their behalf
2. We provide quality service and remove barriers to health services
3. We are health care innovators and embrace change quickly
4. We respect each other and value ethical business practices
5. We are careful in the management of our financial resources and serve as prudent stewards of the public's funds

This is the Molina Way

# Recognized for Quality, Innovation and Success
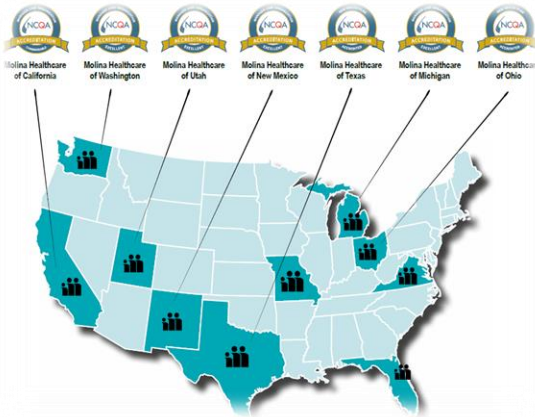
Molina Healthcare, Inc.

- Molina Healthcare plans have been ranked among America's top Medicaid plans by U.S. News & World Report and NCQA.

- 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

- Ranked as the 2nd largest Hispanic owned company by *Hispanic Business* magazine in 2009

- Recognized for innovation in multi-cultural health care by The Robert Wood Johnson Foundation

- Dr. J. Mario Molina, CEO of Molina Healthcare, recognized by Time Magazine as one of the 25 most influential Hispanics in America
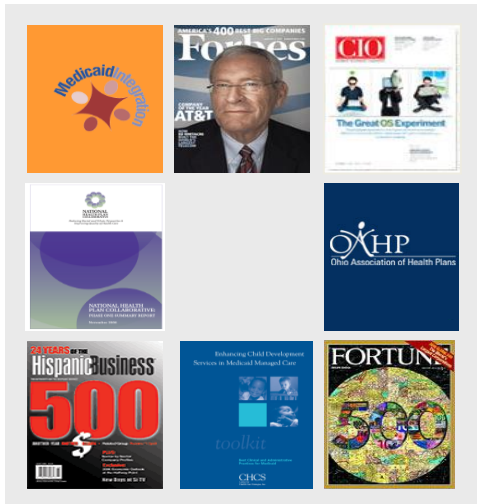
What is the Medicare-Medicaid Program (MMP)?

The Centers for Medicare & Medicaid Services (CMS) and the State of Texas Health and Human Services Commission (HHSC) established a federal-state partnership to implement the Texas Dual Eligibles. Integrated Care Demonstration to better serve individuals eligible for both Medicare and Medicaid (Medicare-Medicaid enrollees).

Objective of MMP

➢ To improve the beneficiary experience in accessing services through:

  ➢ Improving the coordination of care

  ➢ Access to care

  ➢ Increase primary care visits

  ➢ Reduce unnecessary Emergency Room visits

  ➢ Reducing the need for in-patient hospital care and institutional care

➢ Deliver person-centered care

➢ Promote independence in the community

➢ Achieve cost savings for the State and Federal Government through improvements in care coordination

➢ Improve the quality of services

➢ Eliminate cost shifting between Medicare and Medicaid

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MMP Population

Included

➢ Age 21 or older who are enrolled in Medicare and Medicaid

➢ The address of record is within one of the demonstration counties:

  ➢ Bexar

  ➢ El Paso

  ➢ Harris

  ➢ Hidalgo

  ➢ Dallas

  ➢ Tarrant (Molina Healthcare does not currently participate in Tarrant county)

Excluded

➢ Dual eligible individuals receiving services in Intermediate Care Facility for individuals with Intellectual Disabilities or Related Conditions (ICF-IID)

➢ Individuals with developmental disabilities who get services through one of these waivers:

  ➢ Home and Community-based Services (HCS)

  ➢ Community Living and Support Services (CLASS)

  ➢ Texas Home Living (TxHmL)

  ➢ Deaf-Blind Multiple Disabilities (DBMD)

➢ Individuals residing in a State Veterans Home

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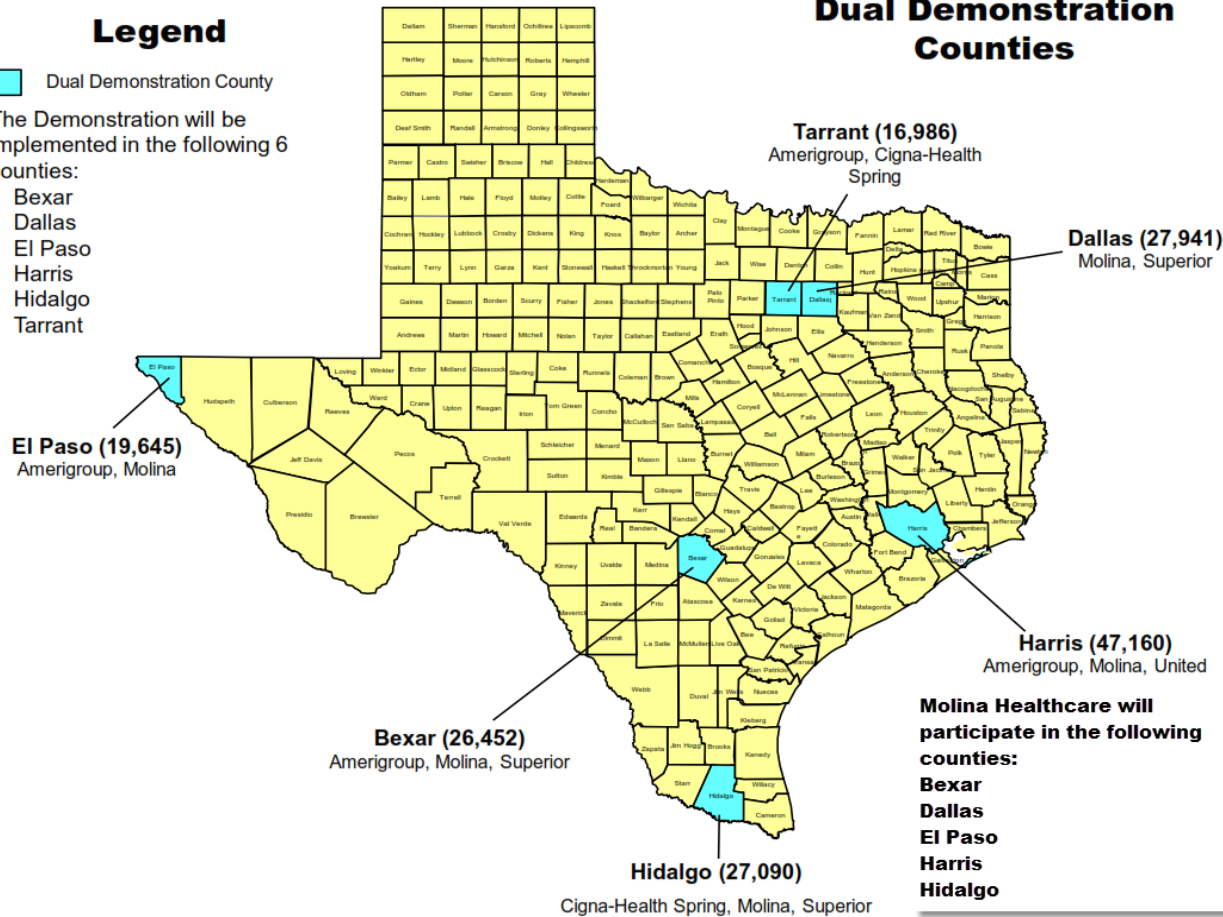
Dual Demonstration Counties

Legend

Dual Demonstration County

The Demonstration will be implemented in the following 6 counties:
- Bexar
- Dallas
- El Paso
- Harris
- Hidalgo
- Tarrant

Dual Demonstration Counties

Tarrant (16,986)
Amerigroup, Cigna-Health Spring

Dallas (27,941)
Molina, Superior

El Paso (19,645)
Amerigroup, Molina

Harris (47,160)
Amerigroup, Molina, United

Bexar (26,452)
Amerigroup, Molina, Superior

Hidalgo (27,090)
Cigna-Health Spring, Molina, Superior

Molina Healthcare will participate in the following counties:
Bexar
Dallas
El Paso
Harris
Hidalgo

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MMP Nursing Facility Value Added Services

Dental Benefit - $250 per year (service date to service date) for dental exam, x-rays, and cleaning

Extra Vision Services – One routine eye exam per year

Hearing Services - $2500 allowance for hearing aides every 2 years

Drug Store Services - $60 per month coverage of approved over the counter healthcare related items

Extra Help with Part D Cost Sharing – Zero Dollars co-payment for Tier One Generic Prescriptions

Extra Good Doctor (Podiatry) Services – Twelve (12) routine visits per year

Stop-Smoking Program – Molina uses a national stop-smoking program, called Quit for Life®.

Personal Grooming Kit - One time for new Members within 30 days of confirmed enrollment

Personal Blanket - One time for new Members within 30 days of confirmed enrollment

Wheelchair/walker accessory -One time accessory for new Members within 30 days of confirmed enrollment

$20 Gift Card diabetic Members who complete a diabetic retinopathy exam per year
$20 Gift Card for diabetic Members who complete an HbA1c lab test per year
$20 Gift Card for Members with cardiovascular disease for completed cholesterol blood test annually
$20 Gift Card for Female Members who complete a cervical Cancer Screening annually
$20 Gift Card for Female Members that complete a recommended Mammogram each year

Enrollment

Voluntary Enrollment

Eligible members may choose to enroll into a particular STAR+PLUS MMP effective March 1, 2015. Eligible members who do not select a STAR+PLUS MMP , or who do not opt out of the demonstration, will be assigned to a STAR+PLUS MMP during passive enrollment.

Request to enroll, which includes enrollment or change from one STAR+PLUS MMP into a different STAR+PLUS MMP:

➢ Will be accepted through the 12th of the month for an effective coverage on the first calendar day of the next month.
➢ Enrollment requests received after the 12th of the month will be effective the first calendar day of the second month following the initial receipt of the request.

Passive Enrollment

Beginning no sooner than April 1, 2015, passive enrollment will be used to assign eligible members who do not select a STAR+PLUS MMP, opt-out or disenroll from the demonstration. Passive enrollment is effective no sooner than 60 calendar days after the beneficiary notification of plan selection, and the right to select a different STAR+PLUS MMP or the option to opt-out until the last day of the month prior to the enrollment effective date.

Individuals enrolled in a Medicare Advantage plan other than a participating MMP or Accountable Care Organization (ACO) will not be passively enrolled, nor will they be required to change to a participating MMP.

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Passive Enrollment Schedule

Intro letter	60 day letter	30 day reminder	Enrollment Start Date	Population
January 2015	N/A	N/A	March 1, 2015 (opt-in)	Any eligible client who opts-in
January 2015	Feb 1, 2015	March 2, 2015	April 1, 2015	20% of eligible non-facility clients by zip code in all demo counties
February 2015	March 2, 2015	April 1, 2015	May 1, 2015	20% of eligible non-facility clients by zip code in all demo counties
March 2015	April 1, 2015	May 1, 2015	June 1, 2015	20% of eligible non-facility clients by zip code
April 2015	May 1, 2015	June 1, 2015	July 1, 2015	20% of eligible non-facility clients by zip code
May 2015	June 1, 2015	July 1, 2015	August 1, 2015	20% of eligible non-facility clients by zip code. All eligible NF residents in Bexar and El Paso
June 2015	July 1, 2015	Aug 1, 2015	Sept 1, 2015	All eligible NF residents in Harris
July 2015	August 1, 2015	Sept 1, 2015	Oct 1, 2015	All eligible NF residents in Dallas, Hidalgo and Tarrant

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Disenrollment

A member may request disenrollment from an MMP in any month for any reason.

The member may disenroll by:

➢ Enrolling in another STAR+PLUS MMP or Medicare Advantage plan

➢ Elect to receive services through Medicare fee-for-service (FFS) and a prescription drug plan

➢ If a member moves outside the dual demonstration county, the member should change their address of record with the State or may disenroll through the State enrollment broker.

State enrollment broker - Maximus (800) 964-2777

Loss of Medicare and/or Medicaid Eligibility

➤ An individual cannot remain a member in an MMP if he/she is no longer entitled to both Medicare Part A and Part B benefits. The State will be notified by CMS that entitlement has ended, and CMS will make the disenrollment effective the first day of the month following the last month of entitlement to either Medicare Part A or Part B benefits (whichever occurred first).

➤ An individual cannot remain a member in MMP if he/she is no longer eligible for Medicaid benefits. Generally, members will be disenrolled from the MMP on the first of the month following the State's notification to the MMP of the individual's loss of eligibility.

➤ The MMP must offer the full continuum of MMP benefits through the end of the calendar month in which the state notifies the MMP of the loss of Medicaid eligibility or loss of State-specific requirements.

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Service Coordination

Molina Service Coordinators:

➢ RN's dedicated to Nursing Facilities

➢ Assigned by Nursing Facility

➢ Notify the NF of change of Service Coordinator within 10 days

➢ Return calls from the NF within 24 hours

➢ Coordinating services when a member transitions into NF, discharges, or transitions from the NF

➢ Participating in NF care planning meetings telephonically or in person, provided the member does not object

➢ Partner as member of the Interdisciplinary Team (IDT):

  ➢ Interview member/family – assisting them to understand benefits

  ➢ Speak with clinical/direct staff about member condition and needs

  ➢ Review and obtain records – ie: MDS, H&P, Labs, etc.

  ➢ Determine changes or updates on member conditions/services

  ➢ Determine current services in anticipation of future care needs

  ➢ Determine preventive care needs/services

  ➢ Identify providers to address specific needs

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Care Management Design

Based on the level of Care Management needed, outreach is made to the member to determine the best plan to achieve short and long-term goals. Each level of the program has its own specific health assessment used to determine interventions that support member achievement of short- and long-term goals. At the higher levels, this includes building an individualized care plan with the member and/or representative. These assessments include the following elements based on NCQA, state and federal guidelines:

- Health status and diagnoses
- Cultural and linguistic needs
- Caregiver resources
- Body Mass Index, Smoking
- Communication barriers with providers
- Emergency Department and inpatient use
- Psychosocial needs (e.g., food, clothing, employment)
- Health goals
- Chemical dependency

- Clinical history, Medications prescribed
- Visual and hearing needs
- Available benefits and community resources
- Confidence
- Treatment and medication adherence
- Primary Care Physician visits
- Durable medical equipment needs
- Mental health

- Readiness to change and Member's desire / interest in self-directing their care
- Life-planning activities (e.g., healthcare power of attorney, advance directives)
- Activities of daily living, functional status, need for or use of LTSS

The resulting care plan is approved by the member, maybe reviewed by the ICT and maintained and updated by the Case Manager as the member's condition changes. The Case Manager also addresses barriers with the member and/or caregiver, and collaborates with providers to ensure the member is receiving the right care, in the right setting, with the right provider.

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Primary Care Physician (PCP) Assignment and Changes

PCP Assignment- Members have the right to choose their PCP. If the Member or his/her designated representative does not choose a PCP, one will be assigned using the following considerations:

➢ Proximity of the provider must be within 10 miles or 30 minutes from the member's residence
➢ Members last PCP, if known
➢ Member's age, gender and PCP needs
➢ Member's language preference

Nursing Facility Attending Physician

➢ May serve as the PCP, but must be contracted and credentialed with Molina as a network provider.
➢ May continue to see the member in the nursing facility without a contract, but will be reimbursed as a non-participating provider
➢ Physician services do not require prior authorization

PCP Changes – Members may change their PCP at any time. All changes completed by the 25th of the month will be in effect on the first day of the following calendar month. Any changes on or after the 26th of the month will be in effect on the first day of the second calendar month.

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Continuity of Care

Members who are receiving skilled nursing facility (SNF) benefits and/or outpatient services (formerly Part B therapy) on the effective date their passive or voluntary enrollment will continue to receive those services under the Continuity of Care provision.

Nursing Facilities should request authorization for any member receiving skilled nursing facility (SNF) benefits and/or outpatient services (formerly Part B Therapy) on the day the passive or voluntary enrollment becomes effective. An authorization number will be required for a claim to be processed, including those covered under the Continuity of Care provision.

Nursing Facilities may refer to the Common Working File or the MESAV to determine MMP eligibility, or contact Molina Member Services.

> **Example:**   Member is receiving Medicare Fee for Service skilled nursing facility benefits on 7/31/15.   The member is passively enrolled in MMP effective 8/1/15.   The Nursing Facility should request authorization for skilled nursing facility care benefits on 8/1/15.

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Pharmacy

Medicaid ONLY Members:

➢ There is no limit on the medicines they can fill each month.

  ➢ Medications are subject the State drug formulary

➢ If an adult (age 21 and older) is transitioning from fee-for-service Medicaid, which currently has a limit on medicines, into managed care, they will receive unlimited prescriptions once they are enrolled in managed care.

Dual Eligible Members (Medicare/Medicaid):

➢ The STAR+PLUS and Medicare formulary will be used as this is an integrated program covering both.

The Pharmacy provider must be contracted and credentialed with Molina

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Pharmacy

(continued)

The MMP Outpatient pharmacy benefit allows for a 90 day transition fill period. Members will be notified by mail when non-formulary medications are filled through the transition fill process and need to follow up with their pharmacy provider.

Medicaid Nursing Home Outpatient Pharmacy benefits allows existing prior authorizations that are sent by the state to be honored until the expiration or 1 year; whichever is shorter. Any new requests are reviewed within 24 hours of receipt on regular business days.

Emergency Pharmacy

➤ A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a prior authorization (PA), either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

➤ The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the member's medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

➤ A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply.

➤ To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit the following information PA Type 8 PA Auth 801.

➤ Call (866) 449-6849 for more information about the 72-hour emergency prescription supply policy.

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Medical Transportation

Emergency Transportation
- When a Member's condition is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, emergency transportation is thus required. Emergency transportation includes but is not limited to ambulance, air, or boat transports.

Emergency Ambulance Transportation does NOT require authorization

Non-Emergency Ambulance transportation
- Molina Healthcare is responsible for authorizing non-emergency ambulance transportation for a Member whose medical condition is such that the use of an ambulance is the only appropriate means of transportation. (i.e., alternate means of transportation are medically contra-indicated.)
- Any Member requiring non-emergency ambulance transportation will be reviewed by the Service Coordinator for medical need and authorization.
- All billing and payment occurs directly between the Ambulance provider and Molina

The nursing facility must obtain prior authorization per HHSC Guidance 9/2015

Ambulance providers must be contracted and credentialed with Molina

Non-Emergency transportation
- The Nursing Facility is responsible for providing routine non-emergency transportation services.
- The cost of such transportation is included in the Nursing Facility Unit Rate.
- Transports of the Nursing Facility Members for rehabilitative treatment (e.g., physical therapy) to outpatient departments, or to physician's offices are not reimbursable services by Molina Healthcare.

Mental Health/Behavioral Health Services

Mental and emotional well-being is essential to overall health. Sound mental health allows people to realize their full potential, live more independent lives, and make meaningful contributions to their communities. Reducing the stigma associated with behavioral health diagnoses is important to utilization of effective behavioral health treatment. Identifying and integrating behavioral health needs into care coordination, traditional health care, social services, person-focused care and community resources, is particularly important.

The following benefits are available to Molina MMP members and are a responsibility of the Health Plan:
- Mental health hospitalization
- Mental health outpatient services
- Psychotropic Drugs
- Mental health services within the scope of primary care physician
- Psychologists
- Psychiatrists

For Molina MMP members, rehabilitative mental health services, including crisis intervention, stabilization and residential, Molina works with and refers to county-administered behavioral health services to coordinate care for Molina members.

How to refer Molina members in need of Mental Health/Behavioral Health services?
- Refer to Molina Prior Authorization requirements [insert link].
- Behavioral health participating providers should fax the Molina Healthcare Inpatient/PHP/IOP/Outpatient Behavioral Health Treatment Request form to Molina for outpatient treatment, to (866) 617-4967
- For both participating and non-participating providers, if the request is for inpatient behavioral health, Partial Hospitalization or an Intensive Outpatient Program for psychiatric and substance use disorders, the Molina Healthcare Inpatient/PHP/IOP/Outpatient Behavioral Health Treatment Request form should be faxed as soon as possible to the same number at (866) 617-4967
- If the admission to inpatient behavioral health is an emergency, prior authorization is not needed but the form should be faxed as soon as possible to (866) 617-4967
- The Molina Care Manager may call the behavioral health provider for additional clinical information, particularly if the Molina Healthcare Inpatient/PHP/IOP/Outpatient Behavioral Health Treatment Request form is not completely filled out.
- Interqual® medical necessity criteria is used to review the provided clinical information. The Molina psychiatrist may also contact the behavioral health provider for a peer-to-peer discussion of the member behavioral health needs.

Crisis Prevention and Behavioral Health Emergencies
- Please contact our Nurse Advice Line available 24 hours a day, 7 days a week at (888) 275-8750 / TTY: (866) 735-2929

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Ancillary Service Providers

Molina encourages current nursing facility ancillary services providers (physicians, dentists, pharmacy, x-ray, lab, ambulance, etc.)
to contract with Molina.

All ancillary service providers must meet credentialing requirements and have a current Medicaid provider number.

The Molina "Contract Request Form" is available on-line at
http://www.molinahealthcare.com/providers/tx/medicaid/forms/PDF/33216_TX_Medicaid_Contract_Request_Form_Final.pdf

Please write *"Nursing Facility Provider"* across the top of the Contract Request Form for expedited processing.

Referrals and Prior Authorization

Referrals are made when medically necessary services are beyond the scope of the PCPs practice. Referrals do not require Prior Authorization unless the service is included in the Prior Authorization list or the referral is to a Non-participating provider. Information should 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 on the Molina Healthcare Prior Authorization Guide are evaluated by licensed nurses and trained staff that have authority to approve services.

A list of services and procedures that require prior authorization can be found on our website:

 http://www.molinahealthcare.com/providers/tx/medicaid/forms/PDF/Prior-Authorization-Guide-2015.pdf

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Request for Authorization

> Authorization for elective services should be requested with supporting clinical documentation prior to the date of the requested service. Authorization for emergent services should be requested within one business day. Information generally required to support decision making includes:
> > Current (up to 6 months), adequate patient history related to the requested services
> > Physical examination that addresses the problem
> > Lab or radiology results to support the request (Including previous MRI, CT, Lab or X-ray report/results)
> > PCP or Specialist progress notes or consultations
> > Any other information or data specific to the request

> MHT will process all "non-urgent" requests from Nursing Facilities in no more than 3 business days of the initial request. "Urgent" requests will be processed within 72 hours of the initial request. If we require additional information we will pend the case and provide written communication to you and the Member on what we need.

> Providers who request prior authorization approval for patient services and/or procedures can request to review the criteria used to make the final decision. Providers may request to speak to the Medical Director who made the determination to approve or deny the service request.

> Upon receipt of prior authorization, MHT will provide you with a Molina unique authorization number. This authorization number must be used on all claims related to the service authorized.

> Our goal is to ensure our members are receiving the Right Services at the Right Time AND in the Right Place. You can help us meet this goal by sending all appropriate information that supports the member's need for Services when you send us your authorization request. Please contact us for any questions/concerns.

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Prior Authorization Work Flow

```
NF Identifies Need for Services
        │
        ▼
NF Requests Prior Authorization with documentation supporting medical necessity via fax or E-Portal
        │
        ▼
Molina Utilization Management (UM) reviews Prior Auth Request and medical necessity documentation
```

UM issues Denial Letter outlining denial reason → NF may request an Appeal on behalf of member

UM requests additional information from NF to make a determination

UM issues Approval letter with authorization number → NF provides services as authorized → NF Identifies need for continued services

Prior Authorization via Molina E-Portal

The preferred method to request a Prior Authorization is through the Molina Provider E-Portal

A Prior Authorization Request submitted through the Molina Provider Portal can be monitored 72 hours after submission by viewing the Nursing Facility's home screen and selecting *Click here to view your recent Service Request/Authorizations.*

Access the Molina Provider Portal: http://www.molinahealthcare.com/providers/tx/medicaid/Pages/home.aspx

➢ Log Into the Provider Portal or if necessary, Register

➢ **Note:** If the Nursing Facility has already been set up on the Provider Portal, you may request access/log in from the designated Portal Administrator in the nursing facility. You can make this request from the Molina Portal log in screen.

Prior Authorization via Fax

Providers should send requests for prior authorizations to the Utilization Management Department using the Molina Healthcare Service Request Form, which is available on our website, at: http://www.molinahealthcare.com/providers/tx/medicaid/forms/PDF/Prior-Authorization-Guide-2015.pdf

Service Request Forms may be faxed to the Utilization Management Department to the numbers listed below.   Supporting medical necessity documentation should be attached to all requests for Prior Authorization.

Phone: (866) 449-6849

Fax: (866) 420-3639

Behavioral Health Fax: (866) 617- 4967

Texas Standard Prior Authorization Request Form for Health Care Services

Molina will accept the Texas Department of Insurance (TDI) Texas Standard Prior Authorization Request Form for Health Care Services via fax. The form and directions for completion can be downloaded from: http://www.tdi.texas.gov/forms/lhlifehealth/nofr001.pdf

Request Forms may be faxed to the Utilization Management Department to the numbers listed below. Supporting medical necessity documentation should be attached to all requests for Prior Authorization Requests.

Phone: **(866) 449-6849**

Fax: **(866) 420-3639**

Behavioral Health Fax: **(866) 617- 4967**

Skilled Nursing Facility Care (SNF)

All skilled nursing facility care requires prior authorization

➢ The 3 day hospital stay requirement is waived and does not apply for MMP members.

➢ Requests for Prior Authorization of SNF care may be submitted by fax or Molina E-Portal.

➢ All requests for SNF must have documentation to support medical necessity.

➢ SNF will be reimbursed based upon Resource Utilization Group (RUG) established by the completion of the Minimum Data Set (MDS) by the nursing facility.

    ➢ The nursing facility must complete the MDS following Medicare guidelines and following the Medicare assessment schedule of 5 Day, 14 Day, 30 Day, 60 Day and 90 Day assessments, as well as off cycle assessments as defined by Medicare guidelines.

➢ Authorizations approved will be for "skilled care" and will not be RUG specific.

➢ SNF will be authorized in 7 day increments dependent upon medical necessity.

➢ Therapy services method of delivery should follow the Medicare guidelines regarding the use of individual, concurrent and group therapy.

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Skilled Nursing Facility (SNF) Prior Authorization via Fax

Prior Authorization via Molina E-Portal

Creating a Prior Authorization request:
➢ Quick Member Eligibility Search – Enter *Member's ID Number or Medicaid ID Number*
➢ Select - *Create Service Request/Authorization*

➢ Member demographics will populate based upon *Quick Member Eligibility Search*

Prior Authorization
Skilled Nursing Facility (SNF)

➢ Type of Service - Select *Inpatient*
➢ Place of Service -Select *Inpatient*
➢ Proposed Start Date – The start date must be the date of Prior Authorization request or later, no authorization can be issued for retroactive dates of service
➢ Care Type – Select *Elective* and or *Urgent*
➢ Reason for *Urgent/Expedite* - To be completed only if request is Urgent. Brief explanation of need (ex. Hospital Discharge planned for XX)
➢ Diagnosis Code – Enter the diagnosis to support the medical necessity of the skilled nursing facility care, search option may be used, it will auto populate Diagnosis Description
➢ Procedure Code – Enter *Procedure Code of 0120 for Skilled Nursing Facility*
➢ Number of Units – Enter "*7".*   Skilled Nursing Facility care will be authorized in 7 day increments dependent upon medical necessity

Non-Skilled NF Outpatient Therapy
(formerly Part B Therapy)

All outpatient therapy requires prior authorization

- Requests for Prior Authorization of Outpatient Therapy may be submitted by fax or Molina E-Portal.
- All requests for Outpatient Therapy must have documentation to support medical necessity.
- Initial therapy evaluations will be reimbursed without a prior authorization, but additional and continued services require prior authorization.
- Outpatient Therapy will be reimbursed based upon prevailing Medicare fee screens as negotiated per contract.
- Therapy services method of delivery should follow the Medicare guidelines regarding the use of individual, concurrent and group therapy.

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Prior Authorization
Non-Skilled NF Outpatient Therapy (formerly Part B)

➢ Type of Service - Select *Therapies*

➢ Place of Service -Select *Outpatient*

➢ Proposed Start Date – The start date must be the date of Prior Authorization request or later, no authorization can be issued for retroactive dates of service

➢ Care Type – Select *Elective* (will be processed within 72 business hours)

➢ Reason for Urgent/Expedite - Leave blank

➢ Diagnosis Code – Enter the diagnosis to support the medical necessity of the requested therapy, search option may be used, it will auto populate Diagnosis Description

➢ Procedure Code – Enter Procedure Codes for therapy using Number of Units then enter number of requested units (unit equals one treatment day)

➢ Procedure Modifier – Enter Modifier

Service Information

Enter Required Information*

Type of Service : * Therapies		Submit Date : 06/08/2015
Place of Service : * Outpatient	Inpatient Notification : * Select	
Proposed Start Date : 06/10/2015 mmddyyyy	Admission Date : * mmddyyyy	Discharge Date : * mmddyyyy

Care Type : ⊙Elective ○Urgent/Expedite Within 72 Hours ○Emergency   Only choose a CARE TYPE if other than a ROUTINE submission

[Remove]	Diagnosis Code		Diagnosis Description
☐	438.0	🔍	COGNITIVE DEFICITS-CEREBRVASC DZ
☐	728.0	🔍	INFECTIVE MYOSITIS
☐	728.87	🔍	MUSCLE WEAKNESS (GENERALIZED)

(Add more diagnoses)

[Remove]	Procedure Code		Procedure Description	Number of Units	Procedure Modifier
☐	97003	🔍	OT EVALUATION	1	go
☐	97001	🔍	PT EVALUATION	1	gp
☐	97535	🔍	SELF CARE MNGMENT TRAINING	15	gp
☐	97110	🔍	THERAPEUTIC EXERCISES	30	go

(Add more procedures)

Prior Authorization (continued)

- ➢ Requester Information – Enter *Name of Nursing Facility and phone number*
- ➢ Contact Information – Enter *Name of Requesting Individual and phone number*
- ➢ Accident Related Information – Select *from drop down box if applicable Enter date as applicable*
- ➢ Pregnancy Related information – as applicable
- ➢ Other Condition Related Information – Select *if appropriate*

Provider Information

* - Required Field

Requester Information

Name : `HEALTHCARE & REHABILITATION  EAST HOUSTON`   Phone # : `28145764..`

Contact Information

Name : * `Rehab Personnel`   Phone # : * `281_555_5555`   Fax # :

Accident Related Information

Accident Code : `Select`   Accident Date : `mmddyyyy`

Pregnancy Related Information

Last Menstrual Date : `mmddyyyy`   Estimated Date of Delivery : `mmddyyyy`

Other Condition Related Information

SELECT CONDITION
- ☐ Chiropractic   Required when healthcare services is requesting chiropractic certification
- ☐ DME   Required when healthcare services is requesting durable medical equipment
- ☐ Oxygen Therapy   Required when healthcare services is requesting oxygen therapy certification
- ☐ Function Limitation   Required when the assessing provider has defined function limitation for the patient
- ☐ Permitted Activities   Required when the assessing provider has defined activities permitted for the patient
- ☐ Mental Status   Required when the patient mental status is relevant to the health care services review

Prior Authorization

(continued)

- ➢ Referring Provider Information – Enter *Nursing Facility NPI*
- ➢ Referred to Provider Information – Enter *Nursing Facility NPI or manually enter fields required*
- ➢ Additional Provider Access – Do not need to complete

Prior Authorization

(continued)

➢ *Referred to Facility Information* will self-populate with entry of the NPI
➢ Attachments – Attach scanned documents which support medical necessity:
  ➢ Physician's order, if for outpatient therapy (formerly Part B). A written telephone order is acceptable for initial request, but continued authorization requests will require a physician's signature
  ➢ Therapy evaluation if requesting outpatient therapy (formerly Part B)
  ➢ Additional supporting documentation as appropriate (examples: nurses notes, monthly summary, physician progress notes, fall history)
  ➢ Continued Authorization Requests should include an updated plan of care
➢ Remarks - Field supports up to 8000 characters for additional information

Refer To Facility Information

To locate a facility enter the facility NPI and move to the next field to search or use the Find Facility link to select. If facility is not found, enter the required information manually.   **Find Facility   Clea**

NPI	Facility Name *
1285735209	I TRANSITIONAL CARE CENTER

Address *	City *	State *	Zip Code *
2109 SOUTH K STREET	MCALLEN	TX	78503

Email	Phone	Fax	Specialty
	:66869100		Select

Supporting Information

You may attach documentation or note in the Clinical Notes/Comments section for your Service Request/Authorization.

Attachments

Type of Attachment : * Select
File :   Browse...   Upload
Upload files only when you want to submit the Service Request/Authorization. Upload up to 5 files at a time that do not exceed a total of 5 MB and continue uploading until you complete the attachments. Each uploaded file cannot have more than 10 pages in the file. Each uploaded file size cannot be greater than 5 MB. The total attachment upload cannot exceed 20 MB

Clinical Notes/Comments   8000 Characters Max. 8000 characters remaining

Remarks:

Prior Authorization
(continued)

➢ If you prefer to fax your documentation, once you submit the request, you will receive the following message:

➢ If *YES* is selected, you will receive a fax cover sheet to include with any Medical Documentation.

Prior Authorization Request Determination

Prior Authorization Request Determination

Denial

➢ If the request is not approved a Denial Letter will be faxed/mailed to the member and the provider.   The Denial Letter will contain the exact reason for denial as well as information on how to appeal the denial.

Approval

➢ If the request is approved an Approval Letter will sent faxed/mailed to the member and the provider containing a specific authorization number which will need to used during the claiming filing process.

Grievances and Appeals

Molina Dual Options STAR+PLUS MMP Enrollees have the right to file and submit a grievance and/or appeal through a formal process. Enrollees may elect a personal representative or a provider to file the grievance or appeal on their behalf.

➢ **Standard Appeal -** Molina Healthcare will accept any information or evidence concerning the appeal received orally or in writing no later than sixty (60) days after the Organization determination date. The Plan will thoroughly review, track and process the appeal within fifteen **(15) days** unless an extension is granted.

➢ **Expedited Appeal -** Molina Healthcare will accept any information or evidence concerning the appeal received orally or in writing no later than sixty (60) days after the Organization determination date. The Plan will thoroughly review, track and process the appeal within twenty-four (24) of submission and may extend this timeframe by up to fourteen (14) days if you request an extension, or if additional information is needed and the extension is in your best interest.

Grievances and Appeals

Grievance/Complaint – Grievance procedures are as follows:

➢ Molina Healthcare will accept any information or evidence concerning the grievance orally or in writing not later than sixty (60) days after the event and will thoroughly investigate, track and process the grievance within thirty (30) days unless an extension is granted;

➢ Complaints concerning the timely receipt of services already provided are considered grievances.

➢ Complaints or disputes involving organization determinations are processed as appeals.

➢ All other issues are processed as grievances.

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Verifying Member Eligibility

Member eligibility can be determined in the following ways:

➢ Molina Provider E-Portal
   https://eportal.molinahealthcare.com/Provider/login

➢ Molina's Member Services/IVR Automated System (866) 449-6849

➢ Molina MMP Services/IVR Automated System (866) 856-8699

➢ Member's issued Plan ID card (not a guarantee of enrollment or payment)

➢ Member Medicare Benefits: IVR Novitas Solutions (855) 252-8782

➢ Texas Benefits provider helpline at (855) 827-3747

➢ TexMedConnect on the TMHP website at www.tmhp.com

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Verifying Member Eligibility
(continued)

➤ Molina Provider E-Portal
   https://eportal.molinahealthcare.com/Provider/login

Back to Member Eligibility Inquiry   Eligibility Information is current as of Jun 23 2015 08:00:08 AM PST

Member Eligibility Details

Quick View	**Member Information**	**Quick Links**
✔ Member is currently enrolled	Member ID: 400000011100	Print
	Enrollment Plan: MOLINA DUAL OPTIONS STAR+PLUS MMP	Submit Claim
✔ No Missed Services	Enrollment Status: ACTIVE	Claim Status
	Enrollment Effective Date: 06/01/2015	Submit Service Request/Authorization
✔ No enrollment restrictions	Enrollment Termination Date:	Service Request / Authorization Inquiry

Molina Member ID

Member Details

Member Information · Enrollment Information · Primary Care Provider Information · IPA/Group Information · History

Name: Last Name, First Name
Date of Birth: 12/20/1945
Mailing Address: 11111230 Dallas Street. Houston TX 77777 6
Member #: 400000011100
Gender #: Female
Home #: (555)555-1212
Alternative #:
Mobile #:
Email ID:

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Verifying Member Eligibility in TMHP

TexMedConnect/Medicaid Eligibility and Service Authorization Verification (MESAV) will show Medicaid Eligibility and the managed care segments for Medicaid or MMP managed care members.

STAR+PLUS MMPs have their own plan codes which are listed below and are visible on the MESAV

Dual Demonstration - STAR+PLUS (Eff. 3/1/15)	
4F	Amerigroup Texas, Inc. Bexar
3G	Amerigroup Texas, Inc. El Paso
7Z	Amerigroup Texas, Inc. Harris
6F	Amerigroup Texas, Inc. Tarrant
4G	Molina Healthcare of Texas Bexar
9J	Molina Healthcare of Texas Dallas
3H	Molina Healthcare of Texas El Paso
7V	Molina Healthcare of Texas Harris
H9	Molina Healthcare of Texas Hidalgo
4H	Superior Health Plan Bexar
9K	Superior Health Plan Dallas
HA	Superior Health Plan Hidalgo
7Q	United Healthcare Texas Harris
H8	HealthSpring Hidalgo
6G	HealthSpring Tarrant

Verifying Member Medicare Eligibility

Centers of Medicare and Medicaid (CMS) Common Working File (CWF)

➢ Molina is identified as the Medicare Replacement for 12/01/12 – 05/31/15
➢ Molina MMP is identified effective 06/01/15 - current

MOLINA HEALTHCARE OF TEXAS, INC.	Molina Healthcare of Texas	H8197	Demo	Medicare-Medicaid Plan HMO/HMOPOS		
MOLINA HEALTHCARE OF TEXAS, INC.	Molina Healthcare of Texas,	H7678	Local CCP	HMO/HMOPOS		

Molina Healthcare Sample Member Identification (ID) Cards

Molina Medicaid ID Card- Front

Your Texas Benefits
Health and Human Services Commission

Member name:

Member ID:

Issuer ID: Date card sent:

Note to Provider:

Ask this member for the card from their Medicaid medical plan. Providers should use that card for billing assistance. No medical plan card? Pharmacists can use the non-managed care billing information on the back of this card.

Molina Medicaid ID Card- Back

Need help?   ¿Necesita ayuda?   1-800-252-8263

Members: Keep this card with you. This is your medical ID card. Show this card to your doctor when you get services. To learn more, go to www.YourTexasBenefits.com or call 1-800-252-8263.

Miembros: Lleve esta tarjeta con usted. Muestre esta tarjeta a su doctor al recibir servicios. Para más información, vaya a www.YourTexasBenefits.com o llame al 1-800-252-8263.

THIS CARD DOES NOT GUARANTEE ELIGIBILITY OR PAYMENT FOR SERVICES.

Providers: To verify eligibility, call 1-855-827-3747. Non-pharmacy providers can also verify eligibility at www.YourTexasBenefitsCard.com. Non-managed care pharmacy claims assistance: 1-800-435-4165.

Non-managed care Rx billing: RxBIN: 610084 / RxPCN: DRTXPROD / RxGRP: MEDICAID

TX-CA-1213

Molina MMP ID Card- Front

TEXAS Medicare → Medicaid PLAN
Your Health Plan ★ Your Choice

TEXAS Health and Human Services

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MedicareRx
Prescription Drug Coverage

Member Name: JANE DOE	RxBIN: 004336
Member ID: 500000000000	RxPCN: MEDDADV
Health Plan: 80840	RxGRP: RX5008
Medicaid ID: 500000000	RxID: 500000000000

PCP Name:

PCP Effective Date:

PCP Phone:

H8197-001

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MMP Skilled Nursing Facility (SNF) Claims

➤ Providers will submit one claim for a skilled nursing facility (SNF) stay:
  ➤ Molina will adjudicate the Medicare portion of the claim, automatically create a coinsurance claim and pay both the Medicare and Medicaid claim with one payment and remittance advice.
  ➤ The claim number for this second claim will be noted with an "M" after the original claim number in the Molina E-Portal. This claim will not be visible in the Molina E-Portal until the Medicare claim has processed.
➤ Reimbursement of a skilled nursing facility (SNF) stay will be the lesser of billed charges or the Medicare Resource Utilization Group (RUG) at the negotiated contract rate for each RUG:
  ➤ Day 1 – 20   Molina reimburses the lesser of billed charges or the full contracted amount for each Medicare RUG for a SNF stay
  ➤ Days 21 – 100
  ▪ Members who are custodial care receiving approved skilled services are reimbursed at the lesser of billed charges or the contracted amount for each Medicare RUG minus the member's prorated daily applied income for a SNF stay if the member has an applied income.
  ▪ Members who are receiving an approved SNF stay and do not have an Applied Income as established by the State (usually community based members) are reimbursed the lesser of billed charges or at the full contracted rate for each Medicare RUG.   There is no co-pay for these members.

MMP Skilled Nursing Facility (SNF) Claims (continued)

➢ Non-participating providers will be paid at the lesser of billed charge or 95% of the full contract rate for each Medicare RUG for a SNF stay

➢ Nursing Facilities must continue to collect Applied Income as designated by the State.

➢ Coinsurance will be paid from data received from the State, therefore 3619's must be completed timely, or payment will be delayed.

➢ **Prior authorization is required for a SNF stay – claims without prior authorization will be denied**

➢ MMP Skilled Nursing Facility claims must be submitted within 365 days of beginning date of service.

Clean Claims for MMP Skilled Nursing Facility stay will be adjudicated within 10 days of submission

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MMP Nursing Facility
Out Patient Therapy Claims (formerly Part B)

- ➢ MMP Therapy claims (formerly Part B Therapy) must be billed separately from SNF stay or custodial daily unit rate claims
  - ➢ Therapy services HCPCS codes used for Prior Authorization must also be the same HCPCS codes used for billing
- ➢ Molina reimburses the lesser of billed charges or the contracted amount for each Medicare (FFS) fee screens for out patient therapy services
  - ➢ Non-participating providers will be paid the lesser of billed charges or 95% of the contract rate for each Medicare (FFS) fee screens
- ➢ **Prior authorization is required for Out Patient Therapy – claims without prior authorization will be denied**
- ➢ MMP Therapy claims must be submitted within 365 days of beginning date of service

Clean Claims for MMP Nursing Facility Therapy will be adjudicated within 30 days of submission

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Billing the Member

➢ Nursing Facilities are responsible for the collection of the Member's applied income during the coinsurance period of a SNF stay, as well as during a custodial stay.

➢ Providers may <u>not</u> balance bill the Member for any reason for covered services.

➢ The Provider Agreement with Molina Healthcare of Texas (MHT) requires that your office verify eligibility and obtain approval for those services that require prior authorization.

➢ In the event of a denial of payment, providers shall look solely to MHT for compensation for services rendered, with the exception of any applied income

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Claim Submission Options

On-line submission of claims is available through Molina Provider E-Portal and can be accessed with the following link:

http://www.molinahealthcare.com/providers/tx/medicaid/Pages/home.aspx

EDI Claims Submission – Medicaid & Medicare
    Emdeon Payor ID#20554
    Emdeon Phone: (877) 469-3263

Medicare Replacement and MMP Claims Submission Address:
    Molina Healthcare
    P.O. Box 22719
    Long Beach, CA 91801

Molina Provider E-Portal

Nursing Facility providers may register for access to the Molina E-Portal for self service member eligibility, claims status, provider searches, to submit requests for authorization and to submit claims. The E-Portal is a secure website that allows our providers to perform many self-service functions 24 hours a day, 7 days a week

E-Portal Highlights for Nursing Facility
Member eligibility verification and history
View Coordination of Benefits (COB) information
Submit online service/prior authorization request
Claims status inquiry
Status check of authorization requests
Submit claims online
Run claims reports

Access the Molina Provider E-Portal:
http://www.molinahealthcare.com/providers/tx/medicaid/Pages/home.aspx

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Molina E-Portal Lines of Business

After accessing your nursing facility in the Molina E-Portal use the dropdown box to select the appropriate line of business to view the claim.

The *"Other Lines of Business"* includes MMP and Medicaid claims
The *"Medicare"* is the Medicare Advantage plan claims

Provider Number	Tax ID	NPI	Name of Facility		Last Name	First Name						
QMP0000000000	123456797	987654321	Happy Nursing Home		Employee	John	Linked User	Default Access	123456 Dallas Street, Dallas Tx 77777	TX	OTHER LINES OF BUSINESS
QMP0000000000	123456797	987654321	Happy Nursing Home		Employee	Christina	Facility/Group	No Access	123456 Dallas Street, Dallas Tx 77777	XY	MEDICARE

Entering Claims via the E-Portal

➢ After accessing the E-Portal
- ➢ Select *Claims*
- ➢ Select *Create Institutional Claim (UB04)*
- ➢ All fields with an asterisk are required information
- ➢ Code MMP claims the same as a Medicare FSS claim

Entering Claims via the E-Portal

(continued)

> ➢ All fields with an asterisk are required information
> ➢ Code MMP claims the same as a Medicare FSS claim

Entering Claims via the E-Portal

(continued)

Electronic Funds Transfer & Remittance Advice (EFT & ERA)

Molina Healthcare has partnered with our payment vendor, FIS 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 Healthcare.

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 you have questions regarding the actual registration process, please contact ProviderNet at: (877) 389-1160 or email: Provider.Services@fisglobal.com

MOLINA HEALTHCARE
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Quality Improvement

Quality is a Molina core value and ensuring members receive the right care in the right place at right time is everyone's responsibility. Molina's quality improvement department maintains key processes and continuing initiatives to ensure measurable improvements in the care and service provided to our members. Clinical and service quality is measured/evaluated/monitored through the following programs:

➢ Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Health Plan Survey (CAHPS®), CMS STARs and other quality measures
➢ Provider Satisfaction Surveys
➢ Health Management Programs:
   ➢ Breathe with ease asthma program, Healthy Living with Diabetes, Chronic Obstructive Pulmonary Disease program, Heart-Healthy Living Cardiovascular program, Motherhood Matters pregnancy program to support and educate members and to provide special care to those with high risk pregnancy
   ➢ For more information on Molina Healthcare's Health Management Program, please call: Health Education **(877) 711-7455.**
➢ Preventive Care and Clinical Practice Guidelines

For additional information about MHT's Quality Improvement initiatives, you can call **(877) 711-7455,** or visit our website: www.molinaheatlhcare.com

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Disability, Literacy and Competency Training

Chronic Conditions and Access to Services

Molina Medicare and Medicare/Medicaid (Duals) members have numerous chronic health conditions that require the coordination and provision of a wide array of health care services. Chronic conditions within this population include, but are not limited to: cardiovascular disease, diabetes, congestive heart failure, osteoarthritis, and mental health disorders. These members can benefit from Molina's integrated care management approach. If you identify a member in need of such services, **please make the appropriate/timely referral to case management at (866) 409-0039.** This will also allow us to continue to expand access for this population to not only Primary Care Providers but also Long Term Support Services, Mental Health Providers, Community Supports and Medical Specialists. This will improve the quality of health for our members.

Prejudices

Physicians and other health professionals who encounter people with disabilities in their professional practice should be aware not only of the causes, consequences, and treatment of disabling health conditions, but also of the incorrect assumptions about disability that result from stigmatized views about people with disabilities that are common within society. Providers shall not differentiate or discriminate in providing Covered Services to any Member because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, disability, physical, sensory or mental health handicap, socioeconomic status, chronic medical condition or participation in publicly financed programs of health care.

Americans with Disabilities Act (ADA)

The ADA prohibits discrimination against people with disabilities, including discrimination that may affect: employment, public accommodations (including health care), activities of state and local government, transportation, and telecommunications. The ADA is based on three underlying values: equal opportunity, integration, and full participation. Compliance with the ADA extends, expands, and enhances the experience for ALL Americans accessing health care and ensures that people with disabilities will receive health and preventive care that offers the same full and equal access as is provided to others.
For additional information or questions on ADA, please contact our "Bridge2Access Connections" at (877) Molina7. Also, please refer to Molina Provider Education Series document – Americans with Disabilities Act (ADA) Questions & Answers for Healthcare

Providers brochure.

Disability, Literacy and Competency Training

Section 504 of the Rehabilitation Act of 1973

A civil rights law that prohibits discrimination on the basis of disability in programs and activities, public and private, that receive federal financial assistance. Section 504 forbids organizations and employers, such as hospitals, nursing homes, mental health centers and human service programs, from excluding or denying individuals with disabilities an equal opportunity to receive program benefits and services. Protected individuals under this law include: any person who (1) has a physical or mental impairment that substantially limits one or more major life activities, (2) has a record of such an impairment or (3) is regarded as having such an impairment. Major life activities include walking, seeing, hearing, speaking, breathing, learning, working, caring for oneself, and performing manual tasks. Some examples of impairments which may substantially limit major life activities, even with the help of medication or aids/devices, are: AIDS, alcoholism, blindness or visual impairment, cancer, deafness or hearing impairment, diabetes, drug addiction, heart disease, and mental illness.

For additional information or questions on ADA, please contact our "Bridge2Access Connections" at (877) Molina7.

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Disability, Literacy and Competency Training

Barriers

By reducing or eliminating barriers to health care access, we can improve health and quality of life for people with disabilities. Some of the most prevalent barriers for seniors and people with disabilities are:

- Physical Access: Ability to get to (access to Public Transportation and adequate parking), in to (including proper waiting room furniture and exam room equipment to meet the needs of all members), and through buildings including ensuring proper signage and way finding (e.g., color and symbol signage) are displayed throughout the facility.
- Communication Access: Ensuring that a sign language or foreign language interpreter is present
- Medical Equipment Access: Ability to safely transfer on tables, access to diagnostic equipment
- Attitudinal: opinions and/or prejudices about a persons quality of life; embracing the idea that disability, chronic conditions and wellness exist simultaneously.

Another barrier to accessing healthcare may be related to out of pocket expenses, utilization management, and care coordination. These barriers effect our members more often than others because of limited incomes, high utilization of health care services, limited education and complexities of the system.

Molina Healthcare makes every effort to ensure that our provider's offices and equipment are accessible and make accommodations for people with disabilities. For questions or further information is needed [i.e. materials in accessible format (large size print, audio, and Braille), need sign language or interpreter services], please contact our Member Services Department or "Bridge2Access Connections" at (877) Molina7

MOLINA HEALTHCARE

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Disability, Literacy and Competency Training

Person-Centered Model of Care

A team based approach in which providers partner with patients and their families to identify and meet all of a patient's comprehensive needs. The purpose of a Person-Centered Model of Care is to provide continuous and coordinated care to maximize health outcomes while involving the patient in their own health care decisions.

Planning

Services and supports should be planned and implemented with each member's individual needs, preferences and health care decisions in mind. Member's should be given the authority to manage their health care and supports as they wish with as much or as little assistance as they need. All necessary information should be given to the member so that they can make the best decision for themselves. Individuals should also have the freedom of choice when it comes to Provider selection.

Self-Determination

Self-determination can be defined as the process when individuals with disabilities and their families control decisions about their health care and have a say in what resources are used to support them. Self-determination can foster independent living for dual eligible members and can also improve quality of life.

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Disability, Literacy and Competency Training

Social Model vs. Medical Model of Disability

There is a fundamental difference between how people with disabilities are seen by society and how the disability community sees themselves.

Medical Model of Disability	Social Model of Disability
Disability is a deficiency or abnormality	Disability is only a difference
Being disabled is negative	Being disabled, in itself is neutral
Disability resides in the individual	Disability derives from interaction between the individual & society
The remedy for disability-related problems is a cure or normalization of the individual	The remedy for disability-related problems are a change in the interaction between the individual and society
The agent of the remedy is the professional	The agent of remedy can be the individual, an advocate or anyone who affects the arrangements between the individual and society

Independent Living Philosophy

Developed by a group of students in Berkley, CA who were frustrated by the degree to which control over their lives had been taken over by medical and rehabilitation professionals. Their experiences gave birth to the philosophy that **"The freedom to make choices and the ability to live in the community is a basic civil right that should be extended to all people – regardless of disability**". The students believed that they didn't need to change to become integrated, but rather the environment and the attitudes toward persons with disabilities needed to change.

This is the philosophy of the Independent Living Centers (ILC's), a network of nationwide consumer controlled, community based, cross disability, non-residential private nonprofit agencies with centers in Texas and across the United States. ILC staff work with consumers to promote independence in the community contrary to other agencies that may take on a *caretake*r or *protector* role. ILCs believe that the freedom to make choices, including mistakes, empowers people to further their involvement in their life and community.

For more information on the Independent Living Philosophy or other Disability issues, contact Molina's "Bridge2Access Connections" at (877) Molina7.

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Disability, Literacy and Competency Training

The Recovery Model

The mental health Recovery Model is a treatment concept wherein a service environment is designed such that individuals have primary control over decisions about their own care. This is in contrast to most traditional models of service delivery, in which individuals are instructed what to do, or simply have things done for them with minimal, if any, consultation for their opinions. The Recovery Model is based on the concepts of strengths and empowerment, saying that if individuals with mental illnesses have greater control and choice in their treatment, they will be able to take increased control and initiative in their lives. Providers should continue to provide members education about the possible outcomes that may result from various decisions and respect the value and worth of each individual as an equal and important member of society.

Evidence Based Practices & Quality Outcomes

Evidence-based practice involves identifying, assessing, and implementing strategies that are supported by scientific research and maximizes three core principles: They are supported by the best research evidence available that links them to desired outcomes, they require clinical skill and expertise to select and apply a given practice appropriately, and they must be responsive to the individual desires and values of consumers, which includes consideration of individual problems, strengths, personality, sociocultural context and preferences.

Providers should strive for Quality Outcomes for each of their patients. Helping individuals achieve their highest level health and everyday function. Goals should be set for each patient and these goals should shape that patients treatment plan. Quality Outcomes can be measured by using key factors such as:

- Patient's Satisfaction
- Level of Improvement concerning their condition or disease
- Functional Progress

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Cultural and Linguistic Expertise

National census data shows that the United States' population is becoming increasingly diverse. Molina has a thirty-year history of developing targeted healthcare programs for a culturally diverse membership and is well-positioned to successfully serve these growing populations by:

- Contracting with a diverse network of community-oriented providers who have the capabilities to address the linguistic and cultural needs of our members;
- Educating employees about the differing needs among Members; and
- Developing member education material in a variety of media and languages and ensure that the literacy level is appropriate for our target audience.

Providers are required to participate in and cooperate with Molina's provider education and training efforts as well as member education and efforts. Providers are also to comply with all health education, cultural and linguistic, and disability standards, policies, and procedures.

Additional Cultural and Linguistic Resources are available to providers such as:
- Low-literacy materials
- Translated documents
- Accessible formats (i.e. Braille, audio or large font)
- Cultural sensitivity trainings and cultural/linguistic consultation

Questions? "Ask the Cultural and Linguistics Specialist" at:
http://molinahealthcare.com/medicaid/providers/ca/resource/ask_cultural.html

Note – Interpretive Services

- MHT has interpreter services on a 24 hour basis. Please contact Member Services toll-free at: **(866) 856-8699**
- for more information.

- If you have a deaf or hard of hearing members, please contact us through our dedicated TTY line, toll-free, at **(800) 735-2989**

- MHT provides twenty four (24) hours/seven (7) days a week Nurse Advice Services for members. The Nurse Advice Line provides access to 24 hour interpretive services. Members may call Molina Healthcare's Nurse Advice Line directly (English line (888) 275-8750) or (Spanish line at (866) 648-3537) or for assistance in other languages. *The Nurse Advice TTY is (866) 735-2929.* The Nurse Advice Line telephone numbers are also printed on membership cards.

Member Rights and Responsibilities

Member Rights

- To be treated with respect and recognition of their dignity by everyone who works with MHC.
- To receive information about MHT, our providers, our doctors, our services and member's right's and responsibilities.
- To choose their primary care physician (PCP) from MHT's network.
- To be informed about their health. If members are ill, members have the right to be told about treatment options regardless of cost or benefit coverage. Members also have the right to ask for a second opinion about their health condition or to ask for an external independent review of experimental or investigational therapies.
- To have all questions about their health answered.
- To help make decisions about their health care. Members have the right to refuse medical treatment.
- To privacy. MHT keeps their medical records private in accordance with State and Federal laws.
- To see their medical record. Members also have the right to ask for corrections to their medical record and receive a copy of it in compliance with State/Federal requirements.
- To complain about MHT or their care by calling, faxing, e-mailing or writing to MHC's Member Services Department.
- To appeal MHT's decisions. Members have the right to have someone speak for them during the grievance.
- To disenroll from MHT.
- To decide in advance how they want to be cared for in case they have a life-threatening illness or injury.
- To receive interpreter services at no cost to help them talk with their doctor or MHT if they prefer to speak a language other than English.
- To not be asked to bring a friend or family member with them to act as their interpreter.
- To receive information about MHT, their providers, or their health in their preferred language.
- To request and receive materials in other formats such as larger size print and Braille.
- To request information in printed form translated into their preferred language.
- To receive a copy of MHT's drug formulary on request.
- To access minor consent services.
- To exercise these rights without negatively affecting how they are treated by MHT, its providers or the Department of Health Care Services.
- To make recommendations regarding the organization's member rights and responsibilities policies.
- To be free from controls or isolation used to pressure, punish or seek revenge.
- To file a grievance or complaint if they believe their linguistic needs were not met by the plan.
- To request a State Fair Hearing by calling (877) 319-6826
- . Members also have the right to receive information on the reason for which an expedited State Fair Hearing is possible.
- To receive family planning services, treatment for any sexually transmitted disease, emergency care services, from Federally Qualified Health Centers and/or Indian Health Services without receiving prior approval and authorization from MHT.

Member Responsibilities

- Members have the responsibility to cooperate with their doctor and staff. This includes being on time for their visits or calling their doctor if they need to cancel or reschedule an appointment.
- Members have the responsibility to be familiar with and ask questions about their health benefits. If Members have a question about their benefits, they may call MHT's Member Services Department at **(866) 856-8966.**
- Members have the responsibility to provide information to their doctor or MHT that is needed to care for them.
- Members have the responsibility to be active in decisions about their health care.
- Members have the responsibility to follow the care plans and instructions for care that they have agreed on with their doctor(s).
- Members have the responsibility to build and keep a strong patient-doctor relationship.

MOLINA HEALTHCARE

Your Extended Family.

Fraud, Waste, & Abuse

MHT seeks to uphold the highest ethical standards for the provision of health care services to its members, and supports the efforts of federal and state authorities in their enforcement of prohibitions of fraudulent practices by providers or other entities dealing with the provision of health care services.

"Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicare and Medicaid programs, 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 Medicare and Medicaid programs. (42 CFR § 455.2)

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

Examples of Fraud, Waste, & Abuse

Health care fraud includes but is not limited to the making of intentional false statements, misrepresentations or deliberate omissions of material facts from, any record, bill, claim or any other form for the purpose of obtaining payment, compensation or reimbursement for health care services.

By a Member	By a Provider
Lending an ID card to someone who is not entitled to it.	Billing for services, procedures and/or supplies that have not been actually been rendered
Altering the quantity or number of refills on a prescription	Providing services to patients that are not medically necessary
Making false statements to receive medical or pharmacy services	Balancing Billing a Medicaid member for Medicaid covered services
Using someone else's insurance card	Double billing or improper coding of medical claims
Including misleading information on or omitting information from an application for health care coverage or intentionally giving incorrect information to receive benefits	Intentional misrepresentation of manipulating the benefits payable for services, procedures and or supplies, dates on which services and/or treatments were rendered, medical record of service, condition treated or diagnosed, charges or reimbursement, identity of Provider/Practitioner or the recipient of services, "unbundling" of procedures, non-covered treatments to receive payment, "70", and billing for services not provided
Pretending to be someone else to receive services	Concealing patients misuse of Molina Health card
Falsifying claims	Failure to report a patient's forgery/alteration of a prescription

➢ Provider can report suspected fraud, waste and abuse by calling our tip line at **(866) 606-3889**

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False Claims Act, 31 USC Section 3279

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

The term "knowing" is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
- Acts in reckless disregard of the truth or falsity of the information in a claim.

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

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Deficit Reduction Act

On February 8, 2006, President Bush signed into law the Deficit Reduction Act ("DRA"). The law, which became effective on January 1, 2007 aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

Health care entities like Molina Healthcare of Texas who receive or pay out at least $5 million in Medicare and Medicaid funds per year must comply with DRA. Providers doing business with Molina Healthcare of Texas, and their staff, have the same obligation to report any actual or suspected violation of Medicare and Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false claims;
- How providers will detect and prevent fraud, waste, and abuse;
- Employee protected rights as whistleblowers.

The Federal False Claims Act and the Medicaid False Claims Act have Qui Tam language commonly referred to as "whistleblower" provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims Act(s). The whistleblower may also file a lawsuit on their own. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

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Deficit Reduction Act

The Federal False Claims Act and the Medicaid False Claims Act contain some overlapping language related to personal liability. For instance, the Medicaid False Claims Act has the following triggers:

- Presents or causes to be presented to the state a Medicaid claim for payment where the person receiving the benefit or payment is not authorized or eligible to receive it
- Knowingly applies for and receives a Medicaid benefit or payment on behalf of another person, except pursuant to a lawful assignment of benefits, and converts that benefit or payment to their own personal use
- Knowingly makes a false statement or misrepresentation of material fact concerning the conditions or operation of a health care facility in order that the facility may qualify for certification or recertification required by the Medicaid program
- Knowingly makes a claim under the Medicaid program for a service or product that was not provided

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in furthering a false claim are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority
- Two times the amount of back pay plus interest
- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions.

Affected entities who fail to comply with the law will be at risk of forfeiting all Medicaid payments until compliance is met. Molina Healthcare of Texas will take steps to monitor Molina contracted providers to ensure compliance with the law.

Provider Online Directory

Molina Healthcare providers may use the Provider On-line Directory (POD) on our website or call (866) 449-6849.

To find a Medicaid or Medicare provider, visit us at www.molinahealthcare.com and select *Find a Provider*, *Find a Hospital*, or *Find a Pharmacy*.

Molina Quick Reference Phone Guide

APPEALS
P.O. Box 165089
Irving, TX 75016

BEHAVIORAL HEALTH SERVICES
....(800) 818-5837
BH Fax for Prior Authorization ....(866) 617-4967
For Behavioral Health Services in Dallas Service Area
(STAR & STAR+PLUS), please call NorthSTAR at ....(888) 800-6799

CONTRACTING
texasexpansioncontracting@molinahealthcare.com
• How to join the network
• Contract Clarifications
• Fee schedule inquiries

CUSTOMER SERVICE (MEMBERS AND PROVIDERS)
• Claims Status
• Member Eligibility
• Benefit Verification
• Complaint & Appeals Status
Bexar, Harris, Dallas, Jefferson, El Paso &
Hidalgo Service Areas (Voice)..................................(866) 449-6849
....(Fax) (281) 599-8916

DENTAL SERVICES
Denta Quest...(800) 508-6775
Liberty Dental ....(888) 703-6999

ELECTRONIC CLAIMS SUBMISSION VENDORS
• Payor Identification for all - 20554
• Availity, Zirmed, Practice Insight, SSI & EMDEON

MEDICAL MANAGEMENT
• Prior Notification
• Prior Authorization
• Referrals
• Disease Management
STAR+PLUS Service
Coordination Department...........................(Voice) (866) 409-0039
....(Fax) (866) 420-3639

MOLINA COMPLAINTS ADDRESS
N.E. Loop 410
#200, San Antonio,
TX 78216
Bexar, Harris, Dallas, Jefferson, El Paso &
Hidalgo Service Areas 866-449-6849
CHIP Rural Service Area...877-319-6826

NURSE ADVICE LINE
• Clinical Support for Members............................(888) 275-8750 (English)
or ....(866) 648-3537 (Spanish)

PAPER & CORRECTED CLAIMS ADDRESS
P.O. Box 22719
Long Beach, CA 90801

PHARMACY
Prior Authorization
Assistance/Inquiries
....(Voice) (866) 449-6849
....(Fax) (888) 487-9251

PROVIDER SERVICES
Bexar, Harris, Dallas, Jefferson,
El Paso & Hidalgo Service Areas ....(866) 449-6849

STAR+PLUS SERVICE COORDINATION
....(866) 409-0039
....(Fax) (866) 420-3639

MEDICAID CONTACTS

EPORTAL TECHNICAL SUPPORT ....(866) 449-6848
FAMILY PLANNING PROGRAM........................(512) 458-7796
MEDICAID HOTLINE ....(800) 252-8263
MEDICAID PROGRAM MEMBER
Verification (NAIS)..(800) 925-9126
NPI # REQUEST
https://nppes.cms.hhs.gov....................................(800) 925-9126
STARLINK-MEDICAID MANAGED CARE HELPLINE
General Member Assistance...................................(866) 566-8989
STAR & STAR+PLUS PROGRAM ENROLLMENT
PCP Information
Plan Changes
Health Plan Information ....(800) 964-2777
TEXAS DEPARTMENT OF INSURANCE
HMO Division..(512) 322-4266
HMO Complaint...(800) 252-3439
Consumer Division...(512) 463-6500
Consumer Hotline ....(800) 252-3439

Please visit www.MolinaHealthcare.com

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Questions and Comments