MOLINA® HEALTHCARE

Your Extended Family.

Nursing Facility Quick Start Training Guide
STAR+PLUS Nursing Facility Carve In
Texas Medicare Medicaid Program
January 2017
www.molinahealthcare.com

MHTNF_QUICKREFTRAIN_011717 R052417 R063017

Training Agenda

MOLINA HEALTHCARE

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Our Story & Who We Are

Our story is about being a family

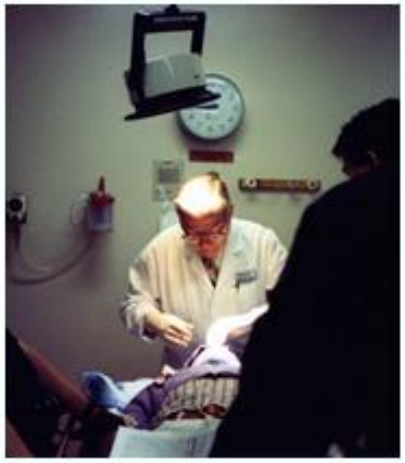
The Molina Healthcare story is about one man's belief that when it comes to health care everyone should be treated like family.

It was in 1980 when as an emergency room physician, C. David Molina, MD, noticed that low-income, uninsured or non-English speaking patients were coming to the emergency room in need of general health care services. Without family doctors, they were not always getting the right care and information. These underserved families deserved better and Dr. Molina set out to do something about it.

He opened a clinic in Long Beach, California to provide low-income individuals and families with a place to go to get personalized health care from Molina doctors. Two more clinics opened that same year and today our health plans and clinics serve patients across the country.

What started out as a mission to treat patients like family has today become a family mission

Never forgetting their roots, Molina children once put in charge of sweeping the floors, stocking shelves and filing medical records now lead the company's operations and strategic direction



Vision, Mission and Values

Our Vision:
We envision a future where everyone receives quality health care.

Our Mission:
To provide quality health care to persons receiving government assistance.

We strive to be an exemplary organization

Our Values:

- **Caring:** We care about those we serve and advocate on their behalf. We assume the best about people and listen so that we can learn.
- **Enthusiastic:** We enthusiastically address problems and seek creative solutions.
- **Respectful:** We respect each other and value ethical business practices.
- **Focused:** We focus on our mission.
- **Thrifty:** We are careful with scarce resources. Little things matter and the nickels add up.
- **Accountable:** We are personally accountable for our actions and collaborate to get results.
- **Feedback:** We strive to improve the organization and achieve meaningful change through feedback and coaching. Feedback is a gift.
- **One Molina:** We are one organization. We are a team.

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Molina Healthcare of Texas

Programs and Services

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Molina Marketplace

(Health Care Exchange)

Molina Marketplace is insurance coverage for those who enroll through the Health Care Exchange

- Requires a separate contract with Molina Healthcare to accept Marketplace members
- Verification of benefits is important due to deductibles and copays that will apply
  - Multiple levels of coverage are available
  - Each coverage level has different deductibles and copays
- **Prior authorization is necessary in order to be paid for a skilled nursing facility stay**
  - The number of available SNF days is limited and can vary by coverage level
  - Verify the number of SNF days previously used

Marketplace Claims

- Follow UB04 Medicare claim format
  - File claim directly on Molina Portal
  - Electronic claim submission
- Clean Claims for Marketplace will be adjudicated within 30 days of submission.
- Filing Deadlines
  - 95 Days from the beginning date of service; OR
  - 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor.

Claims corrections, appeals, and reconsiderations must be completed within <u>120 days from the remittance advice date</u>

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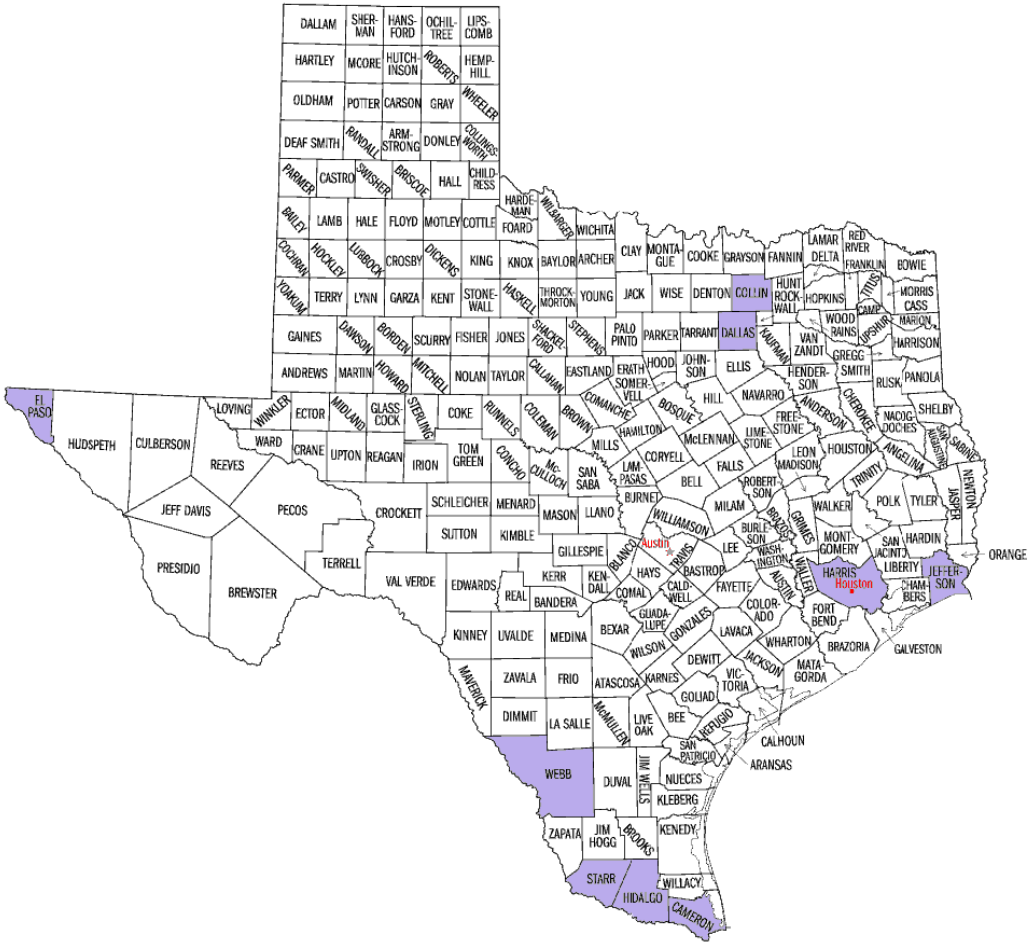
Molina Marketplace

(Healthcare Exchange)

9 Counties:
Cameron, Collin, Dallas, El Paso, Harris, Hidalgo, Jefferson, Starr, Webb



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STAR+PLUS Nursing Facility (NF) Program Medicare Medicaid Program (MMP)

The goal of the STAR+PLUS program and MMP is to integrate acute and long term care services into a managed care delivery system.

Providing nursing facility services through STAR+PLUS and MMP is expected to:

- Improve quality of care for nursing facility residents through coordination of health and service care needs
- Promote care in the least restrictive, most appropriate setting
- Reduce unnecessary Emergency Room visits
- Reduce the need for in-patient hospital care and institutional care
- Deliver person-centered care
- Improve the quality of services
- Eliminate cost shifting between Medicare and Medicaid
- Achieve cost savings for the State and Federal Government through improvements in care coordination

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Populations for STAR+PLUS and MMP

STAR+PLUS

- Age 21 or older who are enrolled in Medicaid residing in a Nursing Facility.
- Meet STAR+PLUS eligibility requirements.

MMP

- Age 21 or older who are enrolled in Medicare and Medicaid, and do not opt out of the demonstration.
- The MMP members whose address of record with the state is within one of the demonstration counties:
  - Bexar
  - El Paso
  - Harris
  - Hidalgo
  - Dallas
  - Tarrant (Molina Healthcare does not currently participate in Tarrant county)
- Members may be residing outside of the demonstration counties and receive MMP services outside the demonstration counties due to their address of record with the State

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STAR+PLUS Roles

Texas Department of Aging and Disability Services (DADS) will:

- Maintain NF licensing, certification, and contracting responsibilities
- Maintain the minimum data set (MDS) function
- Maintain the service authorization data that includes level of care
- Continue trust fund monitoring
- Continue regulatory monitoring activities

Nursing facility providers will:

- Continue to require completion of PASRR (Pre-Admission Screening and Resident Review) Level 1 (PA1) screening
- Continue completing and submitting the MDS to the CMS database
- Continue submitting Long Term Care Medicaid Information (LTCMI) forms to TMHP portal
- Continue submitting 3618/3619 forms to TMHP
- Bill MCO's for services provided to managed care members
- Continue to collect Applied Income as designated by the State
- Meet notification requirements by contacting Molina via fax or phone
  - Phone: 1-866-409-0039
  - Fax: 1-866-420-3639

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STAR+PLUS
Nursing Facility Unit Rate

The NF Unit Rate is set by HHSC based upon the RUG generated by the MDS

- **The NF Unit Rate rates include daily care services such as:**
  - Room and board
  - Medical supplies and equipment
  - Personal needs items
  - Social Services
  - Over-the-counter drugs
  - Applicable nursing facility staff rate enhancements
  - Applicable professional and general liability insurance
  - Non Emergency Transportation
  - Non Emergency Dental Services
- NOTE: There is no skilled nursing facility stay benefit for STAR+PLUS only nursing facility members

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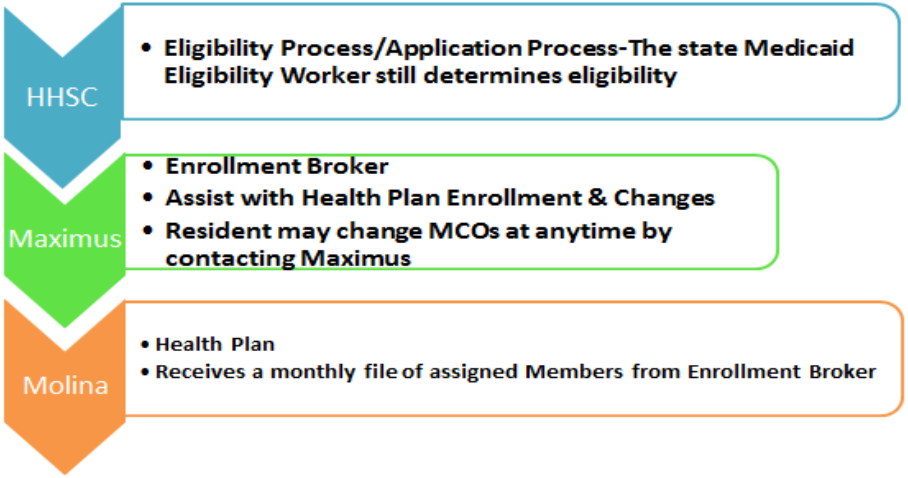
Enrollment

STAR+PLUS



State enrollment broker - Maximus (800) 964-2777

MMP

MMP Members have been passively enrolled per CMS guidelines. The Member may voluntarily 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.

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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Loss of Medicare and/or Medicaid Eligibility - MMP only

- 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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Value Added Services for STAR+PLUS and MMP

STAR PLUS and MMP Value Added Services
Dental Benefit - $250 per year (service date to service date) for dental exam, x-rays, and cleaning
Stop-Smoking Program-Molina uses a national stop-smoking program, Quit for Life
Skid Proof Socks – 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 - diabetic Members who complete a HbA1c lab test
$20 Gift Card - for Members with cardiovascular disease for completed cholesterol blood test annually
Additional Value Added Services for MMP Members Only
Extra Podiatry Services – Twelve (12) routine visits per year.
Extra Vision Services - One routine eye exam per year
Hearing services – One hearing aid for one ear every five years
Zero dollars co-payment for Prescription Drugs
$20 Gift Card for Female Members that complete a recommended Mammogram each year

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Nursing Facility
Provider Services Representative

Provider Services Representative (PSR)

- Is a representative of Molina who is proficient in Nursing Facility billing matters and is able to assist in resolving billing and payment inquiries.
- Each Nursing Facility and Centralized Billing Office is assigned a dedicated PSR and is provided their contact information.
- PSR Staff are former nursing facility business office managers.
- The PSR will establish routine contact with the billing office of the Nursing Facility to provide training, billing and payment resolution.
- Molina will provide the name and contact information of the PSR within 3 days of the effective contract or when there is a change in PSR assignment.
- The PSR will return calls regarding billing and payment matters within 72 hours.
- General Email box available:
  - NFProviderServices@Molinahealthcare.com

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Service Coordination in Nursing Facilities

Service Coordinators (SC) will partner with NF care coordinators and other NF staff to ensure members' care is holistically integrated and coordinated.

- RN's dedicated to Nursing Facilities
- Assigned by Nursing Facility

The goals of Service Coordination include emphasis on:

- Preventive care
- Improved access to care
- Appropriate utilization of services
- Improved member and provider satisfaction
- Improved health outcomes, quality of care and cost effectiveness
- Promotion of care in the least restrictive and most appropriate setting
- Finding ways to avoid preventable hospital admissions, readmissions, and emergency room visits

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Responsibilities of Molina Service Coordinators

- Partner with the member, family, and NF staff in the development of a Molina Service Plan
  - Service Plan to include: Services provided through the NF, add-on services, acute medical services, behavioral health services, and primary or specialty care. The approval of additional services outside of the NF daily unit rate is based on medical necessity and benefit structure.
  - The Service Plan is Molina's document that demonstrates the type of care and services the member is receiving from various healthcare providers.
  - The Molina Service Plan is an internal document and is not part of the member's NF clinical record.
- Comprehensively review the member's Service Plan and NF plan of care, at least annually and as needed with notification of a significant change of condition.
- Support care planning by participating in NF care planning meetings telephonically or in person, provided the member does not object.
- Work with the resident, families, and other service coordinators to ensure smooth transition into the nursing facility.

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Responsibilities of Molina Service Coordinator

- Visit with member on a quarterly basis.
  - Visits to include: A review of the member's Nursing Facility care plan, a person-centered discussion with the member or responsible party about the services and supports the member is receiving, any unmet needs or gaps in the member's care plan, and other aspect of the member's life or situation that may need to be addressed.
- Assisting with the collection of applied income when a NF has documented unsuccessful efforts, per the state-mandated NF requirements.
- Notify the NF within five days of a change to the Molina assigned service coordinator.
- Return a call from the NF within 24 hours.
- Service Coordinators **cannot issue authorizations**, but can assist in making the request for prior authorization through the Molina E-Portal**.**

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Nursing Facility Notifications to Service Coordination

The NF should notify Molina Service Coordination within **one business day** of the following events:

- Unplanned admission or discharge to a hospital or other acute facility, skilled bed, or another nursing home; long term care services and supports (community/home).
- Adverse change in a member's physical or mental condition or environment that could potentially lead to hospitalization.
- Emergency room visit.

Other Notifications:

- Notify the MCO Service Coordinator of any allegations of abuse or neglect or reportable incidents to DADS that involves a Molina member.
  - Provide the Service Coordinator with a copy of the DADS Investigative Report (form 3616A) and supporting documentation for any incident reported to DADS that involves a Molina member.
- Notifying the MCO Service Coordinator of any other important circumstances such as the relocation of residents due to a natural disaster.
- Notifying the MCO Service Coordinator if a member moves into hospice care.
- Notifying the MCO Service Coordinator within **72 hours** of a member's death.

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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 for physicians who have been fully credentialed with Molina. If the physician has not been fully credentialed with Molina, prior authorization is required.

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.

Note: Dual eligible Medicare/Medicaid members (Non MMP) are not required to choose a PCP because they receive acute services from their Medicare providers.

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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 Non MMP (Medicare/Medicaid):

- The STAR+PLUS and Medicare formulary will be used as this is an integrated program covering both.
  - The individual's Part D health plan will cover most medication. Part B also covers certain medications. Medicaid covers a limited number of medications that are not covered by Medicare.

MMP Members

- There is no limit on the medicines they can fill each month under the Medicaid program
  - Medications are subject the State drug formulary. Refer to Vendor Drug Program, TX Medicaid Provider Procedures Manual, and Molina's Portal website for specific codes that require authorization.
  - MMP Skilled – Pharmacy cost included in all inclusive RUG rate.

The Pharmacy provider must be contracted and credentialed with Molina

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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.)
- All billing and payment occurs directly between the Ambulance provider and Molina
- Please refer to HHSC Guidance on NF Non-Emergency Transportation (9/4/15): https://hhs.texas.gov/services/health/medicaid-and-chip/provider-information/contracts-and-manuals/texas-medicaid-and-chip-uniform-managed-care-manual

Nursing Facility providers must obtain authorization

Ambulance providers must be contracted and credentialed with Molina

Routine 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

The following benefits are available to Molina 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 Nursing Facility members, prior authorization must be obtained for the following behavioral health codes ***before*** services are rendered at the nursing facility:

90791	Psych diagnostic evaluation	90847	Family psytx w/patient
90792	Psych diag eval w/med srvcs	99211	Office/outpatient visit est
90832	Psytx pt&/family 30 minutes	99212	Office/outpatient visit est
90834	Psytx pt&/family 45 minutes	99213	Office/outpatient visit est
90837	Psytx pt&/family 60 minutes	99214	Office/outpatient visit est
90846	Family psytx w/o patient	99215	Office/outpatient visit est

The behavioral health provider is responsible for obtaining prior authorization

- Refer to Molina Behavioral Heath Prior Authorization Form:
  http://www.molinahealthcare.com/providers/tx/medicaid/forms/PDF/ Behavioral-Health-Prior-Authorization-Form.pdf

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Hospice Services

STAR+PLUS/MMP (Medicaid)

Hospice services will continue to be billed and paid out of traditional Medicaid fee-for service. (FFS)

- Room and board is billed by the Hospice (same as currently)
- The STAR+PLUS member (Medicaid only) will continue to get their acute services coordinated and paid by Molina (non-hospice related physician services, hospital, pharmacy)

Molina does not need to contract with hospice providers.

MMP (Medicare)

If a member elects to receive the Medicare hospice benefit, the member will remain in the STAR+PLUS /MMP but will obtain hospice service through the Medicare FFS benefit. Medicare hospice services would be paid under the Medicare FFS.

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STAR+PLUS Add-On Services

DADS will continue to authorize services for:

Ventilator Care add-on service:

- To qualify for supplemental reimbursement, a Nursing Facility Member must require artificial ventilation for at least six consecutive hours daily and the use be prescribed by a licensed physician.
  - Authorization will occur by DADS through the MDS submission process and appear on the MESAV

Tracheostomy Care add-on service:

- To qualify for supplement reimbursement a Nursing Facility Member must be less than 22 years of age; require daily cleansing, dressing, and suctioning of a tracheostomy; and be unable to do self-care. The daily care of the tracheostomy must be prescribed by a licensed physician
  - Authorization will occur by DADS through the MDS submission process and appear on the MESAV

Molina will be responsible for the payment of these services

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STAR+PLUS Add-On Services

Molina will prior authorize Add-On services for:

- **PT, OT and Speech (formerly known as GDT)**
  - Includes evaluation and treatment of functions that have been impaired by illness or a significant event
  - Provided with the expectation that the Member's functioning will improve
  - Provided under a written plan of treatment based on the physician's diagnosis and orders

The Nursing Facility must obtain prior authorization of these services

Please see Molina's guide to Nursing Facility STAR+PLUS Add-On Therapy Prior Authorization and Claims Filing Process for detailed instructions at the following link:

http://www.molinahealthcare.com/providers/tx/PDF/Medicaid/Nursing-Facility-STAR-PLUS-Add-on-therapy-prior-authorization-and-claim-filing-process.pdf

- **Augmentative Communication Device (ACD)**
  - The ACD Vendor must obtain prior authorization.
  - The ACD vendor must be credentialed and contracted with Molina

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STAR+PLUS Add-On Services

Emergency Dental Services

Molina Healthcare is responsible for emergency dental services provided to Medicaid Members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for covered emergency dental procedures.

Covered emergency dental procedures include, but are not limited to:

- Alleviation of extreme pain in oral cavity associated with infection or swelling;
- Repair of damage from loss of tooth due to trauma (acute only, no restoration);
- Open or closed reduction of fracture of the maxilla or mandible;
- Repair or laceration in or around oral cavity
- Excision of neoplasms, including benign, malignant and premalignant lesions, tumors and cysts;
- Incision and drainage of cellulitis;
- Root canal therapy. Payment is subject to dental necessity review and pre- and post operative x-rays are required;
- Extractions: single tooth, permanent; single tooth, primary; supernumerary teeth; soft tissue impaction; partial bony impaction; complete bony impaction; surgical extraction of erupted tooth or residual root tip

Emergency dental services do not require an authorization
The Dentist must be contracted and credentialed with Molina

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STAR+PLUS Add-On Services

Medicaid Non-emergency Dental Services:

- Molina is <u>not responsible</u> for paying for the routine dental services provided to Medicaid Members
- Molina is responsible, however, for paying for treatment and devices for craniofacial anomalies.
- The Dentist must be contracted and credentialed with Molina

The Dentist must obtain an authorization for non-emergency services

Dental Incurred Medical Expenses (IME) may still be established for those qualified expenses per Medicaid guidelines

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Molina Value Added Dental Services

One of Molina Healthcare's value added services includes up to **$250 per year** (service date to service date) for dental exam, x-rays, and cleaning for Members.

The Value Added Dental Services must be coordinated through a Molina Healthcare Network provider, and will be paid directly to the Network dental provider.

- Molina will attempt to contract through your current provider subject to credentialing and contracting requirements.

- The Service Coordinator may assist the member in accessing these benefits.

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STAR+PLUS Add-On Services
Custom Powered Wheel Chair

The DME vendor is responsible for obtaining a prior authorization

- NF must collaborate with the DME vendor in the documentation of the request for the CPWC
- Molina will pay the DME vendor directly
- The DME vendor must be credentialed and contracted with Molina
- PASRR related CPWC are processed through TMHP fee for service

Key Criteria for CPWC – must be included with PA request

- Signed statement or written order from a physician that the CPWC is medically necessary
- Seating assessment by a licensed occupational or physical therapist completed in presence of Qualified Rehabilitation Professional employed by the DME vendor
- Evaluation must show that the member is:
  - Unable to ambulate independently more than 10 feet
  - Unable to operate a manual wheelchair
  - Able to safely operate a power wheelchair and all of its medically necessary components and equipment:
    - Trials should be conducted in a power wheelchair to demonstrate ability to independently navigate the typical obstacles found in the environment and functionally operate the powered accessories in a safe manner.
    - Unable to be positioned in a standard power wheelchair
    - Has a mobility status that would be compromised without the CPWC
    - A reasonable expectation that the resident will benefit from the use of the chair for minimum period of 6 months to 5 years

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STAR+PLUS Add-On Services
Custom Powered Wheel Chair

CPWC Modifications

- Modifications are the replacement of components due to changes in the member's condition
- Modifications within the first 6 months after delivery are considered part of the purchase price
- Components that no longer function as they were originally designed are not considered modifications
- Modifications after the first 6 months following the delivery must be sent for prior authorization due to a change in the member's needs, capabilities, or physical or mental status which was unknown or not anticipated

CPWC Adjustments

- Adjustments require labor only and do not include addition, modification, or replacement components or supplies needed to complete the adjustment
- Adjustments are allowable after the first 6 months following delivery of the chair
- Adjustments prior to the first 6 months are considered part of the purchase price
- A maximum of one hour of labor, as needed, may be requested
- Adjustments do not require the purchase of supplies, as this is not defined as a repair

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STAR+PLUS Add-On Services
Custom Powered Wheel Chair

CPWC Replacement

- Prior authorization is required for replace of CPWC prior to five years of the original purchase date when the CPWC no longer meets the member's need.
- Other circumstances that would warrant CPWC replacement:
  - Serious damage was incurred through no fault of the resident
  - If it is determined that the chair was damaged due the abuse by staff of the NF, the NF is responsible for replacing the chair
  - CPWC was stolen and a police report is provided to document the theft

The following items are not a benefit and cannot be billed additionally:

- Additional accessories such as tire pumps, color upgrades, gloves, back packs, USB ports and flags (not considered medically necessary; list not all inclusive)
- Attendant control switch
- Elevator or platform lifts
- **In all other circumstances the NF is responsible for the routine maintenance and repair, including battery replacement of the member's CPWC.**

Please refer to the link for more complete guidance from HHSC regarding CPWC

https://hhs.texas.gov/sites/hhs/files//documents/laws-regulations/handbooks/sph/policy-updates/16-04-11_003.pdf

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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.

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Eligibility

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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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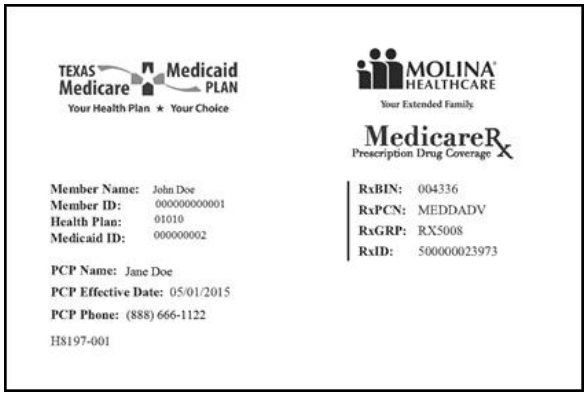
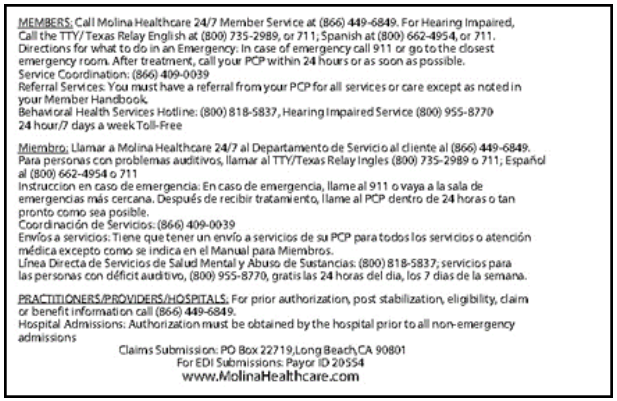
Molina Healthcare Sample Member Identification (ID) Cards

Molina Medicaid ID Card- Front

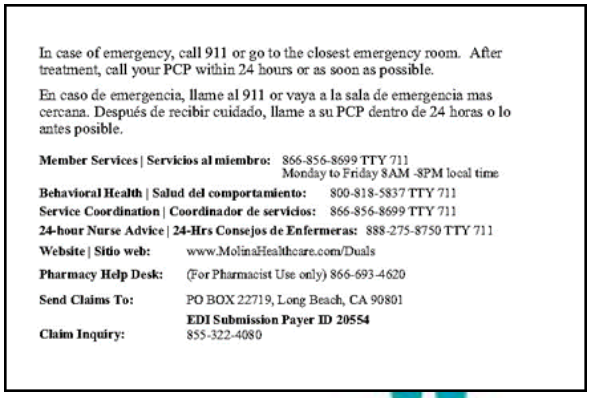
Molina MMP ID Card- Front



Molina Medicaid ID Card- Back



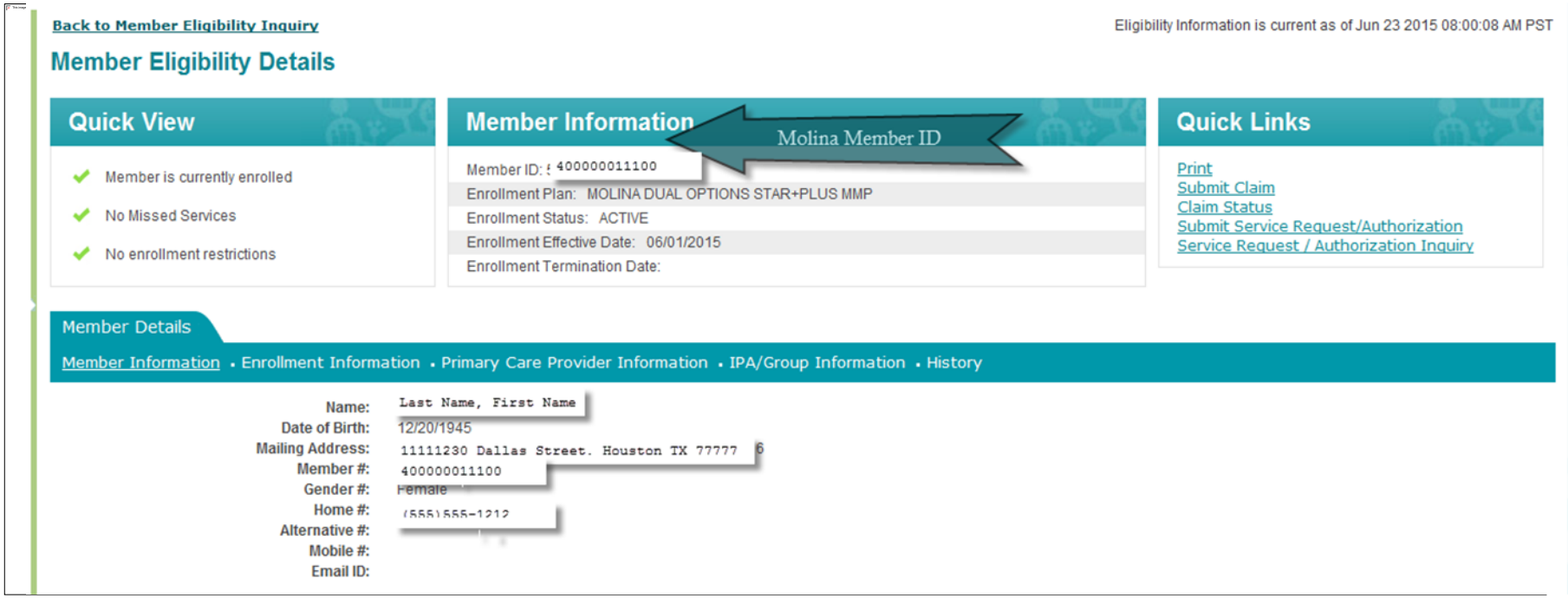
Molina MMP ID Card- Back



MOLINA HEALTHCARE
Your Extended Family

Verifying Member Eligibility in the Molina E-Portal

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



MOLINA HEALTHCARE
Your Extended Family

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

MOLINA HEALTHCARE
Your Extended Family

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

```
A-ENT 060106 A-TRM 000000 B-ENT 060106 B-TRM 000000 DOD 000000 LRSV 60 LPSY 190

DAYS LEFT FULL-HOSP CO-HOSP FULL-SNF CO-SNF  IP-DED BLOOD  DOEBA    DOLBA
CURRENT       46       30        6       80       000     0    021010  031010
PRIOR
PARTB YR 15 DED-TBM 00000 BLD 3 YR 14 DED-TBM 00000 BLD 3      DI 1000000000
FULL-NAME C
PER 6 PLAN-TYP HMO                  CURR  ID H8197 OPT C ENR 060115 TERM
PRIOR PLAN-TYP HMO                  PRIOR ID H7678 OPT C ENR 120112 TERM 053115


PART A YR       BLD  3 PT APL     0.00 OT APL     0.00
CATASTROPHIC A:    DED-TBM BLOOD CO-SNF  FULL-SNF  DOEBA  DOLBA  DED-APL
YEAR   89          0056000   03   008     142    000000 000000 0000000
```

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

Your Extended Family

Prior Authorization

MOLINA HEALTHCARE
Your Extended Family

Prior Authorization (PA)

Prior Authorization is required before rendering designated healthcare services.

- Failure to obtain prior authorization for those designated healthcare services will result in denial of payment for those services.

- The Prior Authorization 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

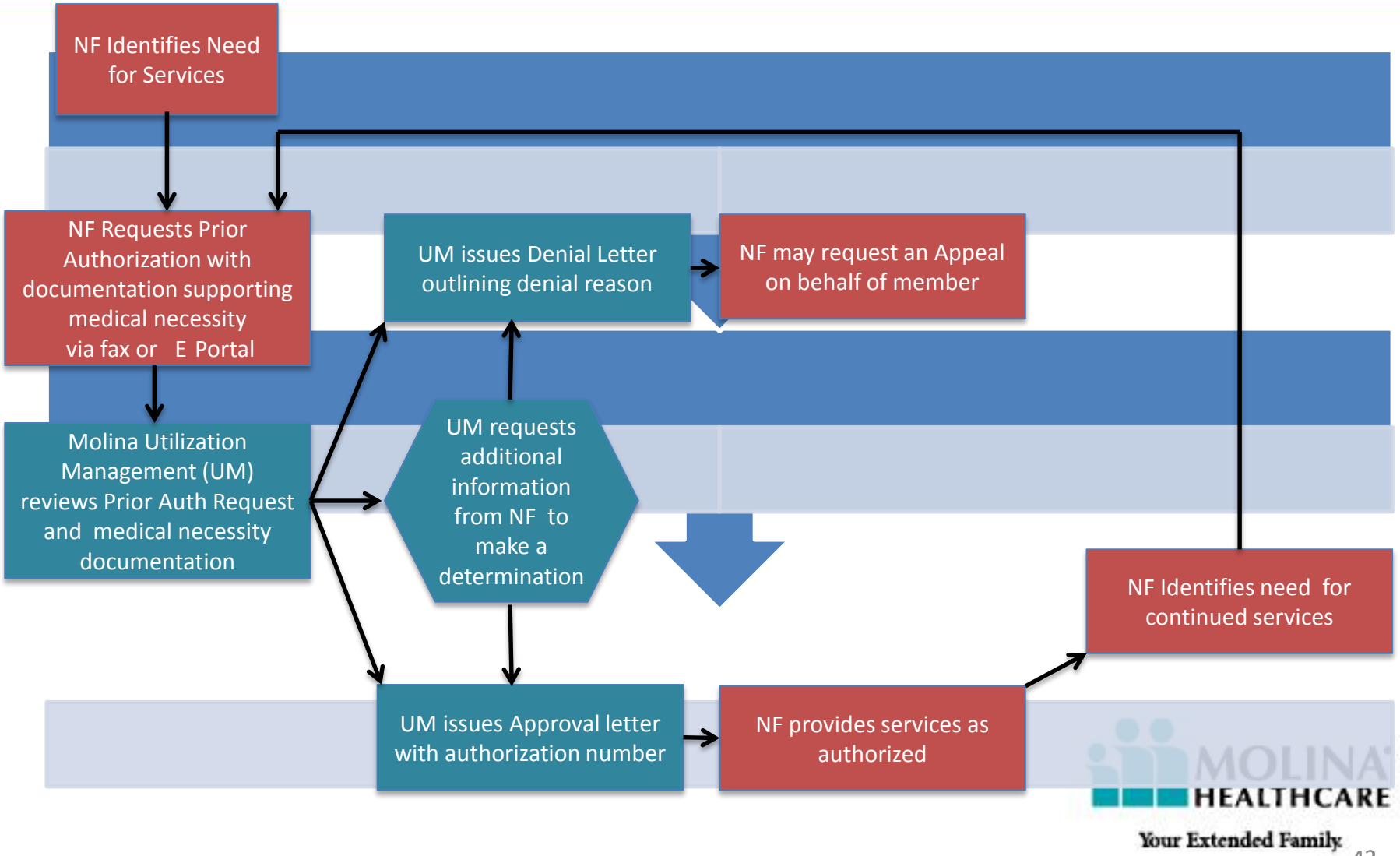
Prior Authorization is required for these common services offered in a Nursing Facility:

- Skilled Nursing Care
- Physical, Occupational, Speech Therapy (Medicaid and MMP)
- Customized Power Wheelchairs
- Behavioral Health Services
- Non-Emergency Ambulance Transportation

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/MHT-Prior-Auth-Guide-Q1-2017.pdf

http://www.molinahealthcare.com/providers/tx/medicaid/forms/PDF/2017-MHT-PA-Code-Matrix-Q1-1-1-17.pdf

Prior Authorization Work Flow



MOLINA HEALTHCARE
Your Extended Family

Request for Prior Authorization

Prior Authorization Requests

- Be specific for services requested
- Include only documentation that supports the request (more is not always better)

  Examples:
  - 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 that supports the request
  - Any other information or data specific to the request

Molina PA Determination

- MHT will process all requests from Nursing Facilities in no more than 3 business days of the initial request
  - Contractually required by HHSC to approve or deny within 3 business days
  - If we require additional information we will pend the case and contact the NF for supplemental information
  - If unable to obtain supplemental information within the 3 business days, then the case will be denied
    - Note: The NF can resubmit the PA with full information

- Notification will be provided in writing to both the provider who requested the service and member
  - If denied, the notice will give the reason for the denial and information on how to appeal
  - The NF may appeal on behalf of the member

- NF may request to speak to the Medical Director who made the determination to approve or deny the service request.

- A unique Molina authorization number will be assigned
  - The authorization number must be used on all claims related to the service authorized.

MOLINA HEALTHCARE

Your Extended Family

STAR+PLUS Add-On Therapy Prior Authorization (formerly Goal Directed Therapy)

All outpatient therapy requires prior authorization

- Requests for Prior Authorization of Add -On Therapy Service may be submitted by fax or Molina E-Portal.
- All requests for Add-On Therapy Service 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.
- Add-On Therapy Service will be reimbursed based upon reimbursement as set by the Medicaid Fee for Service Program.
- Each discipline will receive it's own authorization numbers. Verify all authorizations are included on UB04.
- If the plan of treatment is updated the authorization must be updated as well.

Complete instructions can be accessed by following this link:
http://www.molinahealthcare.com/providers/tx/PDF/Medicaid/Nursing-Facility-STAR-PLUS-Add-on-therapy-prior-authorization-and-claim-filing-process.pdf

MOLINA HEALTHCARE
Your Extended Family

MMP Skilled Nursing Facility (SNF) Care

All skilled nursing facility care requires prior authorization

- The 3 day hospital stay requirement is waived and does not apply for MMP members.
  - Members may be "skilled in place" if the member meets the skilled criteria
- Requests for Prior Authorization of SNF care may be submitted by fax or Molina E-Portal.
- All requests for skilled nursing 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.

MOLINA HEALTHCARE
Your Extended Family

MMP Skilled Nursing Facility (SNF) Care

SNF for Members returning to the same NF after hospitalization

- Prior Authorization Process (applies to returning members only)
  - NF must submit PA request for SNF and supporting documentation within 72 hours of admission
  - Medical necessity must be met for SNF
  - Reimbursed at the contracted Medicare SNF RUG rate back to date of admission if the PA meets medical necessity for SNF
    - Reimbursed back to date of admission at contracted Custodial RUG rate if does not meet medical necessity for SNF

MOLINA HEALTHCARE
Your Extended Family

MMP Nursing Facility 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.
- Authorizations are approved in Units
- 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.
- Each discipline will receive it's own authorization numbers. Verify all authorizations are included on UB04.
- If the plan of treatment is updated the authorization must be updated as well.

MOLINA HEALTHCARE
Your Extended Family

MMP Nursing Facility Outpatient Therapy (formerly Part B Therapy)

APPROVED

Patient Name:

Patient Identification: MBR

Date of Birth: 04/24/1948

Authorization Number: 1618900187

Dates of Service: **From:** 07/08/2016 **To:** 08/08/2016

Number of Units: 48

Comments: SERVICES APPROVED: PT x 48 units 97110 THERAPEUTIC EXERCISES 97112 NEUROMUSCULAR REEDUCATION 97116 GAIT TRAINING THERAPY 97140 MANUAL THERAPY 1 OR GRT REGIONS 97530 THERAPEUTIC ACTIVITIES 97542 WHEELCHAIR MNGMENT TRAINING Thank you

Reviewing Nurse: Merrie
877-665-4622

CONFIDENTIALITY NOTICE: The documents accompanying this telecopy transmission contain confidential information belonging to the sender which is privileged. The information is intended only for the use of the individual(s) or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. If you have received this telecopy in error, please immediately notify us via telephone at the number above or return original documents to address listed above.

Disclaimer: This authorization number is not a guarantee of reimbursement/payment. Reimbursement is based on eligibility, medical necessity, and the benefit provisions of the patient&€™s plan at the time services are rendered. If services, Providers, or dates of service change from the dates indicated, Molina Healthcare must be notified prior to services being rendered or it could result in nonpayment of an associated claim.

Example: Outpatient Therapy Approval notice

MOLINA HEALTHCARE
Your Extended Family

Prior Authorization via Fax

MOLINA HEALTHCARE | MOLINA MEDICARE

Molina Healthcare Medicaid, CHIP, & Medicare Prior Authorization Request Form

Phone Number: (866) 449-6849
Fax Number: (866) 420-3639

MEMBER INFORMATION			
Date of Request:			
Plan:	☐ Molina Medicaid ☐ Molina Medicare	☐ Other:	
Member Name:		DOB:	/ /
Member ID#:		Phone:	( ) -
Service Type:	☐ Elective/Routine	☐ Expedited/Urgent*	

*Definition of Urgent / Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.

Referral/Service Type Requested		
Inpatient ☐ Surgical procedures ☐ ER Admits ☐ SNF ☐ Rehab ☐ LTAC	**Outpatient** ☐ Surgical Procedure ☐ Diagnostic Procedure ☐ Infusion Therapy ☐ Rehab (PT, OT, & ST) ☐ Wound Care ☐ Other:	☐ Home Health ☐ DME ☐ In Office
Diagnosis Code & Description:		
CPT/HCPC Code & Description:		For "J Codes", include # of mgs:
Number of visits requested:	Date(s) of Service:	

Please send clinical notes and any supporting documentation

PROVIDER INFORMATION			
Requesting Provider Name:			
Contact at Requesting Provider's office:			
Phone Number:	( )	Fax Number:	( )
TIN/NPI:		Address:	
Provider/Facility Providing Service:			
Phone Number:	( )	Fax Number:	( )
TIN/NPI:		Address:	

For Molina Use Only:

30156TX0213 rev04162015 2015 TX Molina Healthcare PA GUIDE

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/MHT-Prior-Auth-Guide-Q1-2017.pdf

Service Request Forms may be faxed to the Utilization Management Department at 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**

MOLINA HEALTHCARE
Your Extended Family

STAR+PLUS Add On Therapy Prior Authorization via Fax

MOLINA HEALTHCARE

MOLINA MEDICARE

Molina Healthcare Medicaid, CHIP, & Medicare MMP Dual Options
Prior Authorization Request Form

Fax Number: Utilization Managment: [Medicaid/CHIP/Nursing Facility: (866) 420-3639; MMP/Medicare: (844) 251-1450
Pharmacy: Medicaid/CHIP (888) 487-9251; MMP/Medicare: (866) 290-1309]

MEMBER INFORMATION			
Date of Request:	01/10/17		
Plan:	☒ Molina Medicaid ☐ Molina Medicare	☐ Other:	
Member Name:	Resident Name	DOB:	Monthy Day /Year
Member ID#:	Resident Medicaid Number	Phone:	( ) - Facility Phone Number
Service Type:	☒ Elective/Routine	☐ Expedited/Urgent*	

***Definition of Urgent / Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.**

Referral/Service Type Requested			
Inpatient ☐ Surgical procedures ☐ ER Admits ☐ SNF ☐ Rehab ☐ LTAC	**Outpatient** ☐ Surgical Procedure ☐ Diagnostic Procedure ☐ Infusion Therapy	☒ Rehab (PT, OT, & ST) ☐ Hyperbaric Therapy ☐ Pain Management ☐ Other:	☐ **Home Health** ☐ **DME** ☐ **Wheelchair** ☐ **In Office**
Diagnosis Code & Description:	ICD10 diagnosis code & Description as related to need for therapy		
CPT/HCPC Code & Description:	Use CPT codes from DADS crosswalk	For "J Codes", include # of mgs:	
Number of visits requested:	# of visits	Date(s) of Service:	Expected date span of therapy, starting date may not be before submission of date of prior auth request

Please send clinical notes and any supporting documentation

PROVIDER INFORMATION					
Requesting Provider Name:	Name of Nursing Facility or Individual Therapist if billing individually				
Contact at Requesting Provider's office:	Preferred contact to be the treating therapist				
Phone Number:	(xxx) xxx-xxxx	TPI :		NPI:	NPI of facility
Fax Number:	(xxx) xxx-xxxx	Address:	Address of Facility		
Provider/Facility Providing Service:	Name of Nursing Facility or Individual Therapist if billing individuallly				
Phone Number:	(xxx) xxx-xxxx	TPI:		NPI:	NPI of facility
Fax Number:	(xxx) xxx-xxxx	Address:	Address of Facility		

For Molina Use Only:

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

MOLINA HEALTHCARE
Your Extended Family

Skilled Nursing Facility (SNF) Prior Authorization via Fax

MOLINA HEALTHCARE | MOLINA MEDICARE

Molina Healthcare Medicaid, CHIP, & Medicare Prior Authorization Request Form

Phone Number: (866) 449-6849
Fax Number: (866) 420-3639

MEMBER INFORMATION			
Date of Request:			
Plan:	☐ Molina Medicaid ☐ Molina Medicare	☐ Other:	MMP
Member Name:		**DOB:**	/ /
Member ID#:	Molina Member #	**Phone:**	( ) Facility Phone Number
Service Type:	☐ Elective/Routine	☐ Expedited/Urgent*	

***Definition of Urgent / Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.**

Referral/Service Type Requested			
Inpatient	**Outpatient**		☐ **Home Health**
☐ Surgical procedures	☐ Surgical Procedure	☐ Rehab (PT, OT, & ST)	☐ **DME**
☐ ER Admits	☐ Diagnostic Procedure	☐ Wound Care	
☐ SNF	☐ Infusion Therapy	☐ Other:	☐ **In Office**
☐ Rehab			
☐ LTAC			

Diagnosis Code & Description:	Full Diagnosis Codes supporting reason primary reason for skilled care		
CPT/HCPC Code & Description:	Codes to support skilled	For "J Codes", include # of mgs:	
Number of visits requested:		Date(s) of Service:	Starting date may not be before the submission date of the prior auth request

Please send clinical notes and any supporting documentation

PROVIDER INFORMATION			
Requesting Provider Name:	Nursing Facility Name		
Contact at Requesting Provider's office:	Contact at the Nursing Facility		
Phone Number:	NF Phone Number	Fax Number:	NF Information
TIN/NPI:	NF TIN/NPI	Address:	
Provider/Facility Providing Service:			
Phone Number:	( )	Fax Number:	( )
TIN/NPI:		Address:	

For Molina Use Only:

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2015 TX Molina Healthcare PA GUIDE

MOLINA HEALTHCARE
Your Extended Family

Non-Skilled NF Outpatient Therapy

(formerly Part B)

Prior Authorization via Fax

MOLINA HEALTHCARE MOLINA MEDICARE

Molina Healthcare Medicaid, CHIP, & Medicare Prior Authorization Request Form

Phone Number: (866) 449-6849
Fax Number: (866) 420-3639

MEMBER INFORMATION			
Date of Request:			
Plan:	☐ Molina Medicaid ☐ Molina Medicare	☐ Other:	MMP
Member Name:		DOB:	/ /
Member ID#:	Molina Member #	Phone:	( ) Facility Phone Number
Service Type:	☐ Elective/Routine	☐ Expedited/Urgent*	

*Definition of Urgent / Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.

Referral/Service Type Requested		
Inpatient ☐ Surgical procedures ☐ ER Admits ☐ SNF ☐ Rehab ☐ LTAC	Outpatient ☐ Surgical Procedure ☐ Diagnostic Procedure ☐ Infusion Therapy ☐ Rehab (PT, OT, & ST) ☐ Wound Care ☐ Other:	☐ Home Health ☐ DME ☐ In Office
Diagnosis Code & Description:	Full Diagnosis Codes supporting need for therapy	
CPT/HCPC Code & Description:	Codes for therapy modalities	For "J Codes", include # of mgs:
Number of visits requested:	Date(s) of Service:	Starting date may not be before the submission date of the prior auth request

Please send clinical notes and any supporting documentation

PROVIDER INFORMATION			
Requesting Provider Name:	Nursing Facility Name		
Contact at Requesting Provider's office:	Contact at the Nursing Facility – Usually the Therapist		
Phone Number:	NF Phone Number	Fax Number:	NF Information
TIN/NPI:	NF TIN/NPI	Address:	
Provider/Facility Providing Service:			
Phone Number:	( )	Fax Number:	( )
TIN/NPI:		Address:	

For Molina Use Only:

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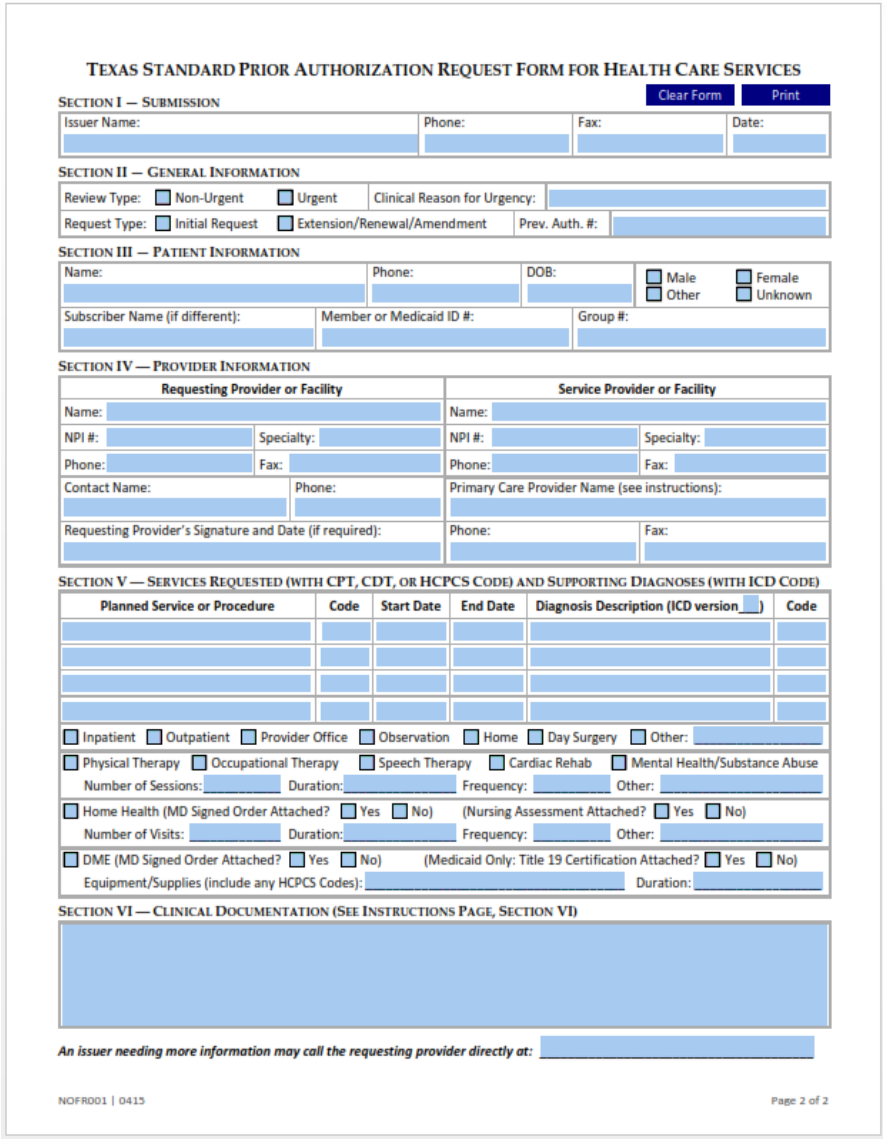
MOLINA HEALTHCARE
Your Extended Family

Texas Standard Prior Authorization Request Form for Health Care Services



TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

Clear Form | Print

SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Date:

SECTION II — GENERAL INFORMATION

Review Type: ☐ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	
Request Type: ☐ Initial Request ☐ Extension/Renewal/Amendment	Prev. Auth. #:	

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☐ Unknown
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:	

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Primary Care Provider Name (see instructions):	
Requesting Provider's Signature and Date (if required):		Phone:	Fax:

SECTION V — SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version ___)	Code

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☐ Other:

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse
Number of Sessions: Duration: Frequency: Other:

☐ Home Health (MD Signed Order Attached? ☐ Yes ☐ No) (Nursing Assessment Attached? ☐ Yes ☐ No)
Number of Visits: Duration: Frequency: Other:

☐ DME (MD Signed Order Attached? ☐ Yes ☐ No) (Medicaid Only: Title 19 Certification Attached? ☐ Yes ☐ No)
Equipment/Supplies (include any HCPCS Codes): Duration:

SECTION VI — CLINICAL DOCUMENTATION (SEE INSTRUCTIONS PAGE, SECTION VI)

An issuer needing more information may call the requesting provider directly at:

NOFR001 | 0415 Page 2 of 2

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.

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

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

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

MOLINA HEALTHCARE

Your Extended Family

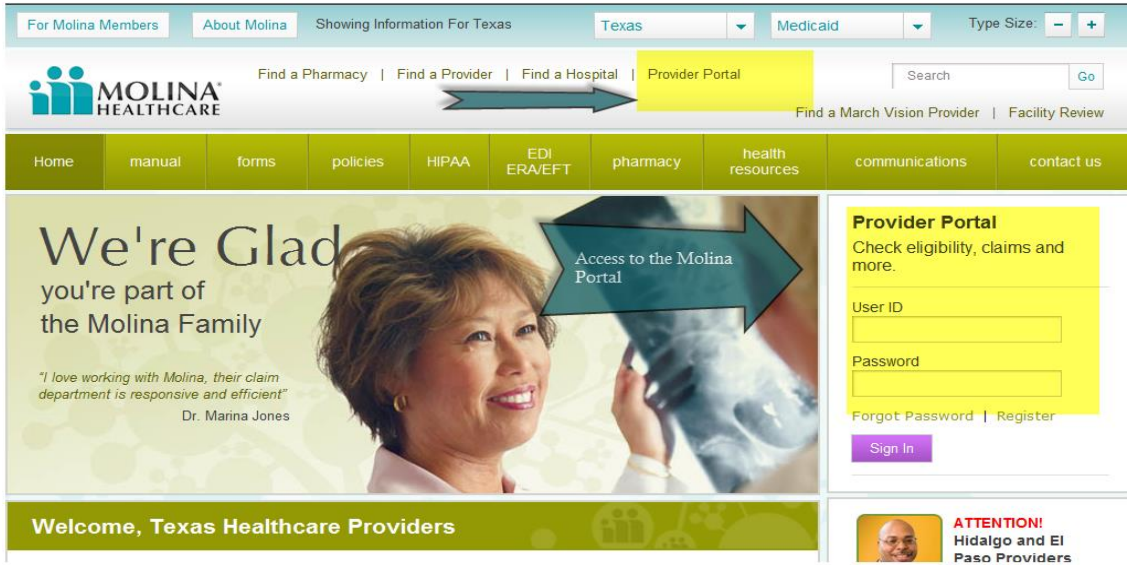
Prior Authorization in the Molina E-Portal

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.

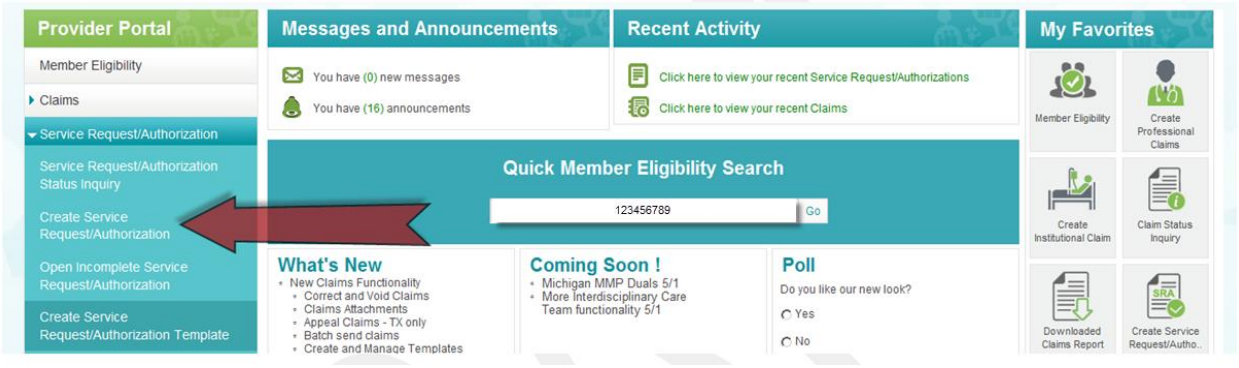


MOLINA HEALTHCARE
Your Extended Family

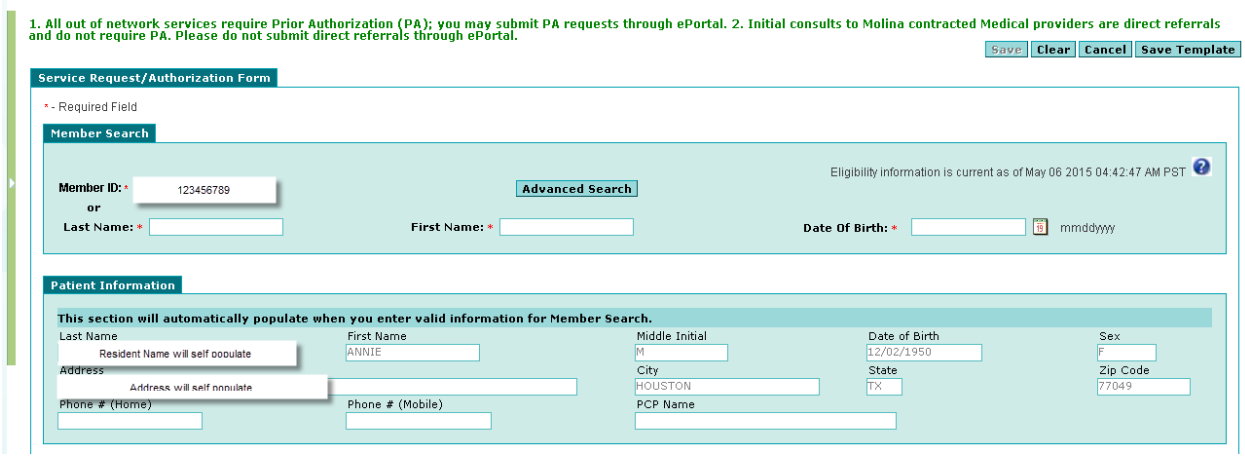
Prior Authorization in the Molina E-Portal continued

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*



MOLINA HEALTHCARE
Your Extended Family

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* (Urgent should not be used in a nursing home setting.)
- 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 or 0110 for Skilled Nursing Facility*
- Number of Units – Enter "*7*". Skilled Nursing Facility care will be authorized in 7 day increments dependent upon medical necessity

MOLINA HEALTHCARE
Your Extended Family

Prior Authorization
NF Outpatient Therapy (formerly Part B Therapy)

- 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
- 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**

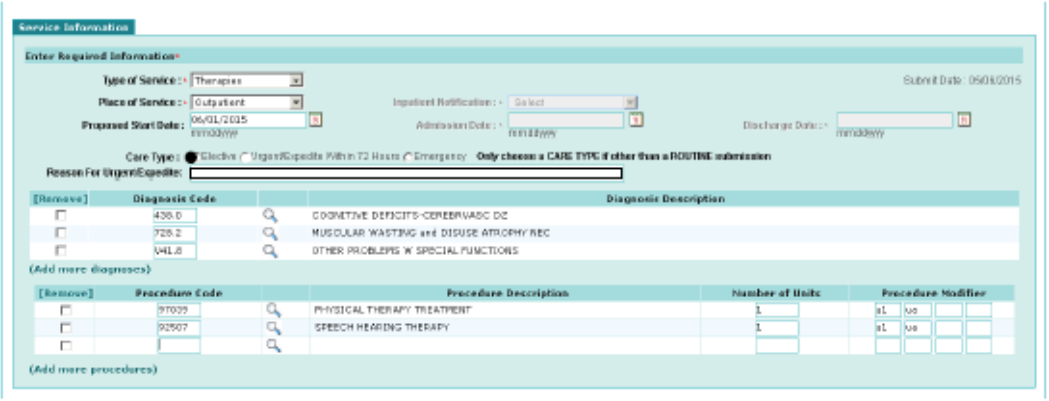
[Remove]	Diagnosis Code		Diagnosis Description
☐	438.0		COGNITIVE DEFICITS-CEREBRVASC DZ
☐	728.0		INFECTIVE MYOSITIS
☐	728.87		MUSCLE WEAKNESS (GENERALIZED)

(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 – Add On Therapy STAR+PLUS Medicaid Only (formerly GDT)



- 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 – will auto populate Diagnosis Description
- Procedure Code – Enter Procedure Codes for therapy using DADS LTC Crosswalk codes only – no other codes are acceptable *NOTE: Code for PT and OT is the same, thus description will be the same, therefore the number of units requested must be combined. Clarify number of PT units requested and number of OT units requested in the remarks field.*
- Number of Units – Enter number of requested units (unit equals one treatment day)
- Procedure Modifier – Enter Modifier using the DADS LTC Crosswalk code only, as shown below

Service	Revenue code	CPT/HCPCS	Modifiers
OT Rehabilitative Service	0431	97039	U1, UA
PT Rehabilitative Service	0421	97039	U1, UA
ST Rehabilitative Service	0441	92507	U1, UA
OT Rehabilitative Service Contracted	0431	97039	U1, UA, GO
PT Rehabilitative Service Contracted	0421	97039	U1, UA, GP
ST Rehabilitative Service Contracted	0441	92507	U1, UA, GN

MOLINA HEALTHCARE
Your Extended Family

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

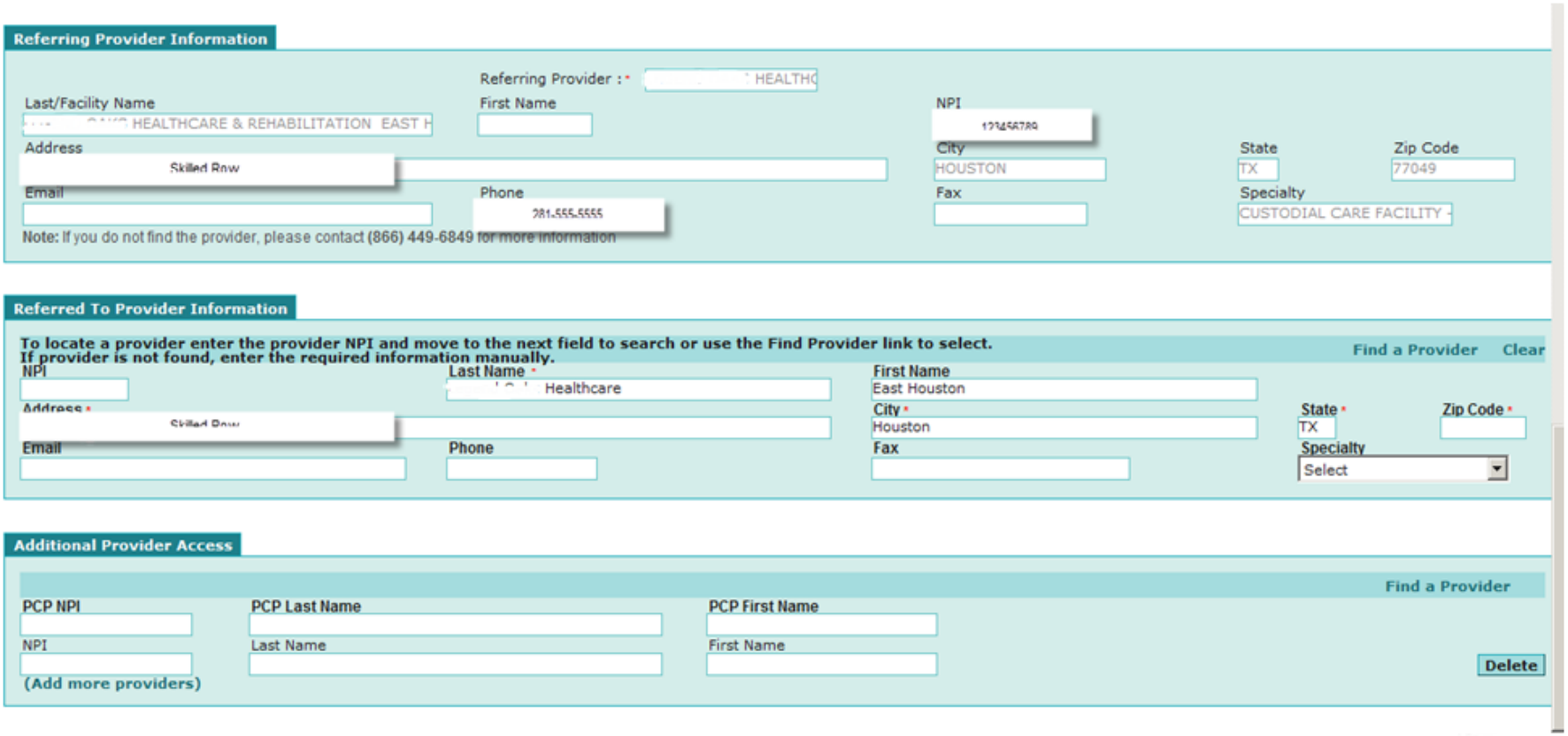
Other Condition Related Information

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

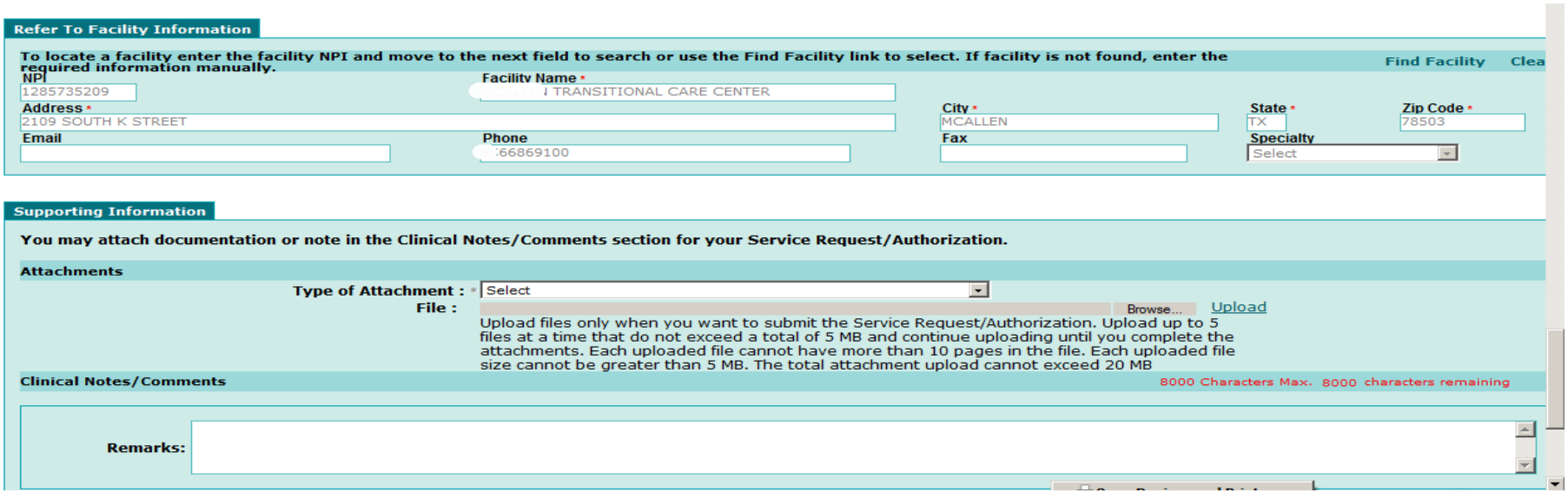
Prior Authorization continued

- 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



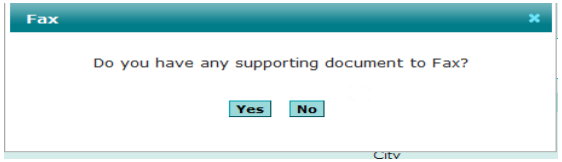
Prior Authorization continued

- *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

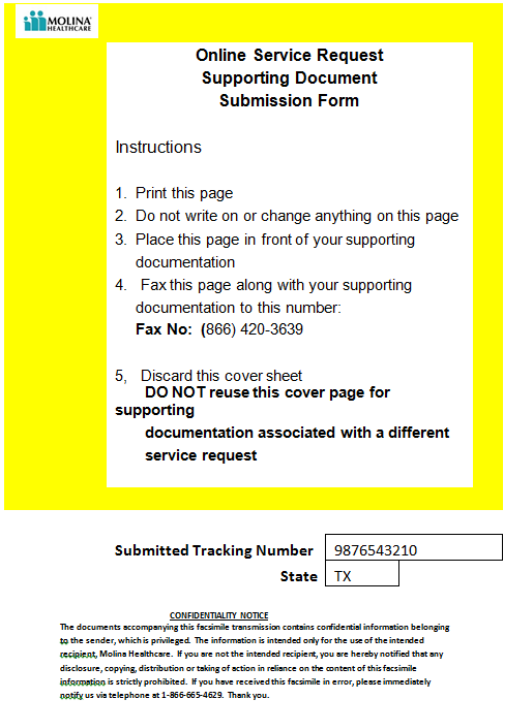


Prior Authorization continued

- 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.



Online Service Request
Supporting Document
Submission Form

Instructions

1. Print this page
2. Do not write on or change anything on this page
3. Place this page in front of your supporting documentation
4. Fax this page along with your supporting documentation to this number:
   Fax No: (866) 420-3639

5, Discard this cover sheet
DO NOT reuse this cover page for supporting documentation associated with a different service request

Submitted Tracking Number 9876543210
State TX

CONFIDENTIALITY NOTICE
The documents accompanying this facsimile transmission contains confidential information belonging to the sender, which is privileged. The information is intended only for the use of the intended recipient, Molina Healthcare. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of action in reliance on the content of this facsimile information is strictly prohibited. If you have received this facsimile in error, please immediately notify us via telephone at 1-866-665-4629. Thank you.

MOLINA HEALTHCARE
Your Extended Family

Claim Processes and Appeals

STAR+PLUS
Nursing Facility Claims

HHSC will set the minimum reimbursement rate paid to nursing facilities under STAR+PLUS, including the staff rate enhancement and general/liability insurance rates.

- Reimbursement rates are set using the Resource Utilization Group (RUG) methodology. Please access the link below for more information:
- http://www.hhsc.state.tx.us/rad/long-term-svcs/downloads/2014-nf-rates.pdf

HHSC will ensure:

- Molina Healthcare's clean claim criteria meets the criteria used by DADS.
- Molina Healthcare will pay clean claims no later than ten calendar days after the submission of a clean claim.
- Nursing facilities can continue to submit claims to TMHP, which will route the claims to the appropriate MCO for processing – TMHP will NOT process claims for qualified STAR+PLUS clients.
- Nursing facilities will continue to submit claims to TMHP for residents not assigned to an MCO (pending Medicaid, non-assigned).

MOLINA HEALTHCARE
Your Extended Family

STAR+PLUS
Nursing Facility Claims

Nursing Facility Unit Rate or Coinsurance claims

- Clean Claims will be adjudicated within 10 days of submission
- Filing Deadlines
  - 365 Days from the beginning date of service; OR
  - 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor.

Claims corrections, appeals, and reconsiderations must be completed within 365 days from the beginning date of service

Nursing Facility Add-On claims

- Clean Claims will be adjudicated within 30 days of submission
- Filing Deadlines
  - 95 Days from the beginning date of service; OR
  - 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor.
- Add-On Services must be billed on a separate claim from Nursing Facility Unit Rate claims

Claims corrections, appeals, and reconsiderations must be completed within 120 days from the remittance advice date

MOLINA HEALTHCARE
Your Extended Family

MMP Skilled Nursing Facility (SNF) Claims

- Providers submit a 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 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 as set by the State Medicaid Eligibility Worker.

MOLINA HEALTHCARE
Your Extended Family

MMP Skilled Nursing Facility (SNF) Claims

- **Prior authorization is required for a SNF stay – claims without prior authorization will be denied**
- Clean Claims for MMP SNF claims will be adjudicated within 10 days of submission
- Filing Deadlines
  - 365 Days from the beginning date of service; OR
  - 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor.
- Molina reimburses the lesser of billed charges or the contracted amount for each Medicare RUG for a SNF stay.
  - Non-participating providers will be paid the lesser of billed charges or 95% of the 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 secondary payment will be delayed.

Claims corrections, appeals, and reconsiderations must be completed within <u>120 days from the remittance advice date</u>

MOLINA HEALTHCARE

Your Extended Family

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

- **Prior authorization is required for Out Patient Therapy – claims without prior authorization will be denied.**
- Clean Claims for MMP Nursing Facility Therapy will be adjudicated within 30 days of submission.
- Filing Deadlines
  - 365 Days from the beginning date of service; OR
  - 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor.
- 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.
- 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.

Corrections, reconsideration, appeals must be filed within
120 days from the remittance advice date

MOLINA HEALTHCARE
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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

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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 not 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.
- Receipt of prior authorization is not a guarantee of payment, as member eligibility is required
- 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

MOLINA HEALTHCARE
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Molina E-Portal Self-Service Functions

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 E-Portal by using this link:
http://www.molinahealthcare.com/providers/tx/medicaid/Pages/home.aspx

MOLINA HEALTHCARE
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Molina E-Portal
Lines of Business

After accessing the correct 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"* includes Medicare Advantage Plan claims only

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

MOLINA HEALTHCARE
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Correcting Claims in the Molina E-Portal

- Previously submitted claims may be corrected in the Molina E-portal in accordance with filing deadlines for the type of claim

- For step by step guidance on correcting claims in the E-Portal please follow the link to the ***Nursing Facilities Partners in Care Fall/Winter 2015 Newsletter***

http://www.molinahealthcare.com/providers/tx/medicaid/comm/PDF/Nursing-Facility-Fall-2015.pdf

For additional training or assistance please contact your assigned Provider Services Representative or email:
NFProviderServices@Molinahealthcare.com

MOLINA HEALTHCARE
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Appealing Claims in the Molina E-Portal

- Claims Inquiry on Molina E-Portal, search for the claim in question.

Click on an underlined column header to sort or hover over a ? for help with that column

Claim ID	Member Name	Billed Amt	Service Date From	Service Date To	Received Date	Submission Type*	Status	Status Date	Claim Type	Attachments
						Select	Select		Select	
12345678	Member Name	1,651.22	12/19/2016	12/31/2016	01/05/2017		Paid	01/06/2017	INSTITUTIONAL	

- Click on the claim ID to open the claim.

Claim Line	Service From Date	Service To Date	Rev Code	Service Code	Modifiers	Units	Billed Amt	Deductible	Co-Ins	Paid Amt	Co-Pay	Line Status Effective	Status	Remit Message
1	12/19/2016	12/31/2016	0100			12	1476.36	0.00	0.00	1396.77	0.00	12/19/2016		
2	12/19/2016	12/31/2016	0100			1	174.86	0.00	0.00	116.40	0.00	12/19/2016		

Showing 1-2 of 2 | 10 | per page | Page 1 of 1

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

For additional training or assistance please contact your assigned Provider Services Representative or email:
NFProviderServices@Molinahealthcare.com

MOLINA HEALTHCARE
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Appealing Claims in the Molina E-Portal

Select “Appeal Claim”

Provider Complaint/Appeal Request Form

Instructions for filling a complaint/appeal:

1. Fill out this form completely. Describe the issue(s) in as much detail as possible.
2. Attach copies of any records you wish to submit.
3. The completed form will be submitted to Molina Healthcare of Texas to Provider Complaints & Appeals. We will send a written acknowledgement of your request. It will be mailed to you within three (3) working days after the request is received.

Provider's Name: Facility Name will

NPI: NPI will populate

Federal ID: Tax ID will populate

Request Type: ○ Complaint ◉ Appeal

Participation Status: ◉ Contract ○ Non - Contracted

Claim Number: 12345678

Date of Service: 12/19/2016 mm/dd/yyyy

Total Charges: 1651.22

Address: Facility Address will populate

City/State/Zip: City, State, Zip will populate

Contact Person: Enter name of person familar with the appeal

Phone: XXX-XXX-XXXX

Member's ID: Member's ID

Member Name: Member's Name

Date of Birth: date of birth mm/dd/yyyy

Specific Issue(s): Please state all details relating to your request including names, dates and places. Attach all supporting materials below to support your request.

Give detailed notes of why you disagree with the way the claim was processed.

Supporting Information

Attachments: Attach copies of any records you wish to submit below

Type of Attachment : Select

File : Browse... Upload

Upload files only when you want to add supporting documents to the claim appeal. Upload 1 file at a time.
Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

Provider Name: Facility Name

Date: 01/10/2017

☐ By entering my name below, I certify that I am either the submitting healthcare provider or that I am legally authorized to act on behalf of the healthcare provider submitting this information. I certify that any and all information in any form submitted to Molina Healthcare is truthful and correct to the best of my knowledge.

Print | Submit | Cancel

MOLINA HEALTHCARE
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Claims Report in Excel from the Molina E-Portal

- Providers have the ability to create a claims report in the Molina E-Portal and export to Excel

MOLINA HEALTHCARE

Claim Report for
Checked between 03/01/201 5

Claim No	Line	Rev.Code	Billed Unit	Amount Paid	Svc From Date	Svc To Date	Member Name	Member ID #	Check #	Check Date	Claim Status
15219933653		1 0100	6	245.11	08/01/2015	08/06/2015	NF Member	123456	EFT2727678	8/10/2015	65-Paid
15240936124		1 0100	19	0	08/01/2015	08/01/2015	NF Member	123456		9/8/2015	65-Paid
15240936124		1 0100	19	0	08/01/2015	08/01/2015	NF Member	123456	EFT2796499	9/8/2015	65-Paid
15226944240		1 0100	7	285.96	08/07/2015	08/13/2015	NF Member	123456	EFT2750679	8/19/2015	65-Paid
15233958281		1 0100	7	285.96	08/14/2015	08/20/2015	NF Member	123456	EFT2762495	8/25/2015	65-Paid
15240936124		2 0100	8	326.81	08/20/2015	08/20/2015	NF Member	123456		9/8/2015	65-Paid
15240936124		2 0100	8	326.81	08/20/2015	08/20/2015	NF Member	123456	EFT2796499	9/8/2015	65-Paid
15244992960		1 0100	3	122.56	08/28/2015	08/30/2015	NF Member	123456	EFT2793331	9/4/2015	65-Paid
15244992960A1		1 0100	3	122.56	08/28/2015	08/30/2015	NF Member	123456	EFT2837142	9/23/2015	65-Paid
15244992960		2 0100	1	40.85	08/31/2015	08/31/2015	NF Member	123456	EFT2793331	9/4/2015	65-Paid
15244992960A1		2 0100	1	99.36	08/31/2015	08/31/2015	NF Member	123456	EFT2837142	9/23/2015	65-Paid

- See complete instructions including Excel formatting at:

http://www.molinahealthcare.com/providers/tx/medicaid/comm/PDF/Nursing-Facility-Fall-2015.pdf

MOLINA HEALTHCARE
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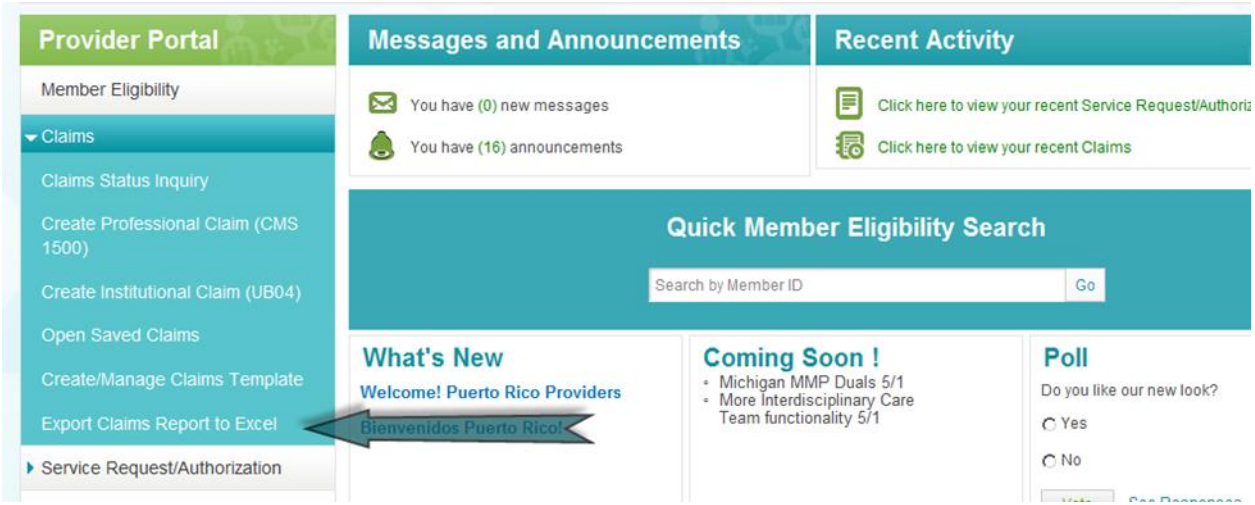
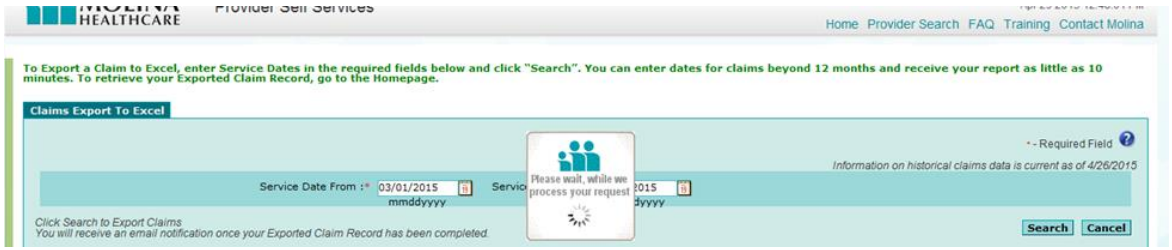
Claims Report in Excel from the Molina E-Portal

From the Molina E- Portal, select *"Export Claims Report to Excel"*



Enter the date range for the report



MOLINA HEALTHCARE
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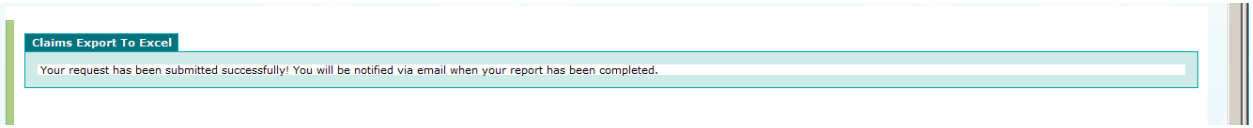
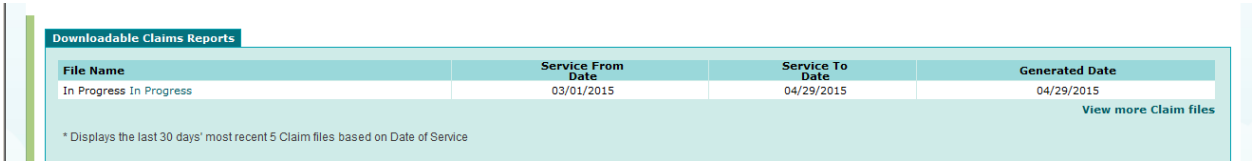
Claims Report in Excel from the Molina E-Portal

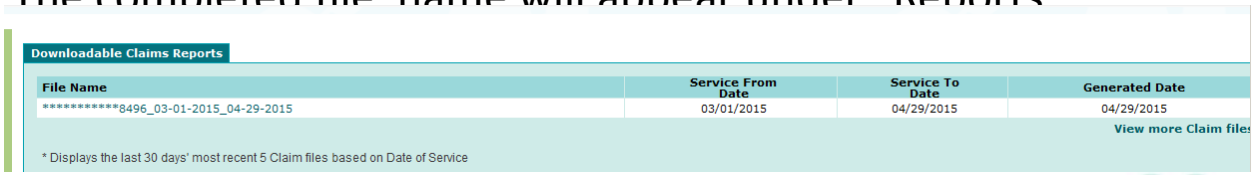
Once the request has been submitted, the user will receive a message that the request was submitted successfully.



When the report is complete, the user will receive an email confirmation. The user can also view the progress of the report on the claim menu bar- " Reports "



The completed file name will appear under "Reports"



MOLINA HEALTHCARE
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Medicaid Eligibility Service Authorization Verification (MESAV)

Using the data provided by HHSC, Molina has developed a MESAV and it is available on the Molina Portal. This data is obtained by Molina Healthcare after it is posted to the TMHP website. Therefore, please expect a delay between data appearing on the TMHP website and the Molina Portal.

Requirements to view a MESAV on the Molina Portal:

- You must have Molina portal log-in access granted by your portal administrator
- MESAV data is specific to the provider number

If assistance is needed with Molina Portal access please contact your Molina Provider Services Representative or email NFProviderServices@Molinahealthcare.com

MOLINA HEALTHCARE
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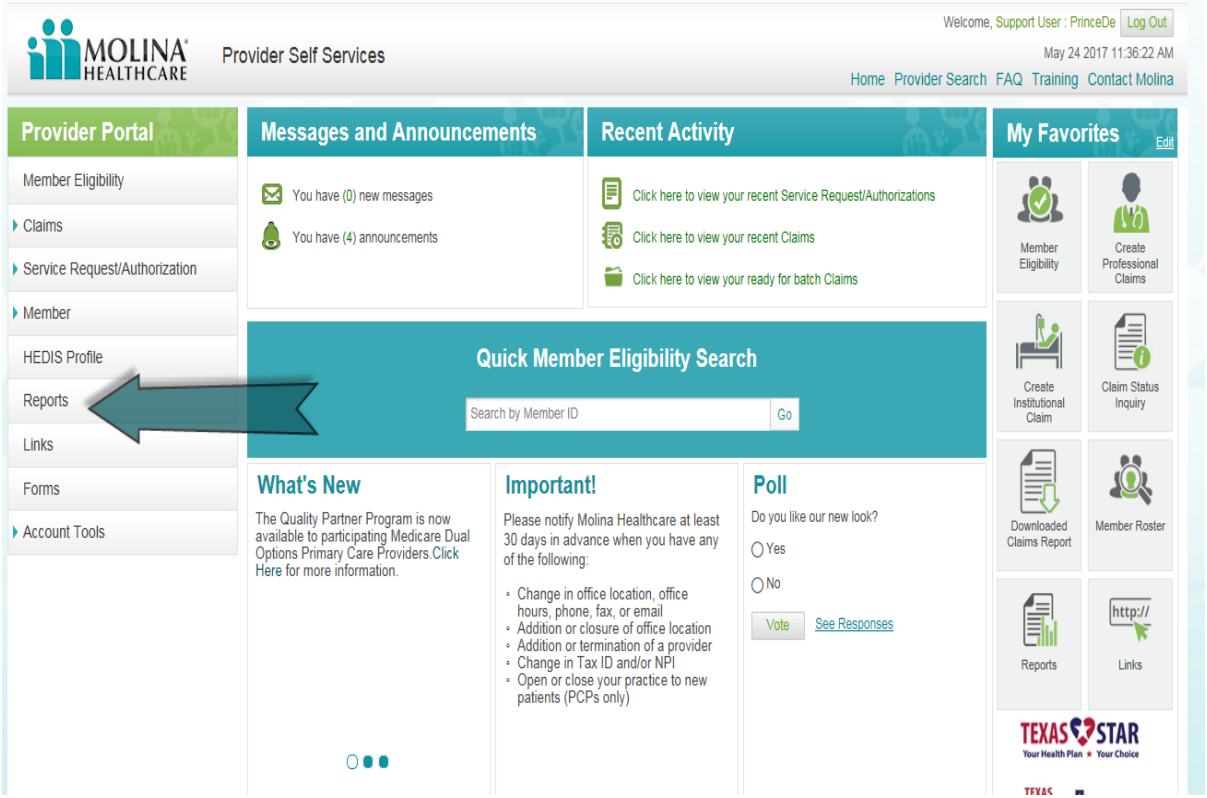
Accessing the Molina Portal MESAV

- Access the Molina Provider Portal Home page https://provider.molinahealthcare.com/provider/login
- Select “Reports” from the left side bar menu



MOLINA HEALTHCARE
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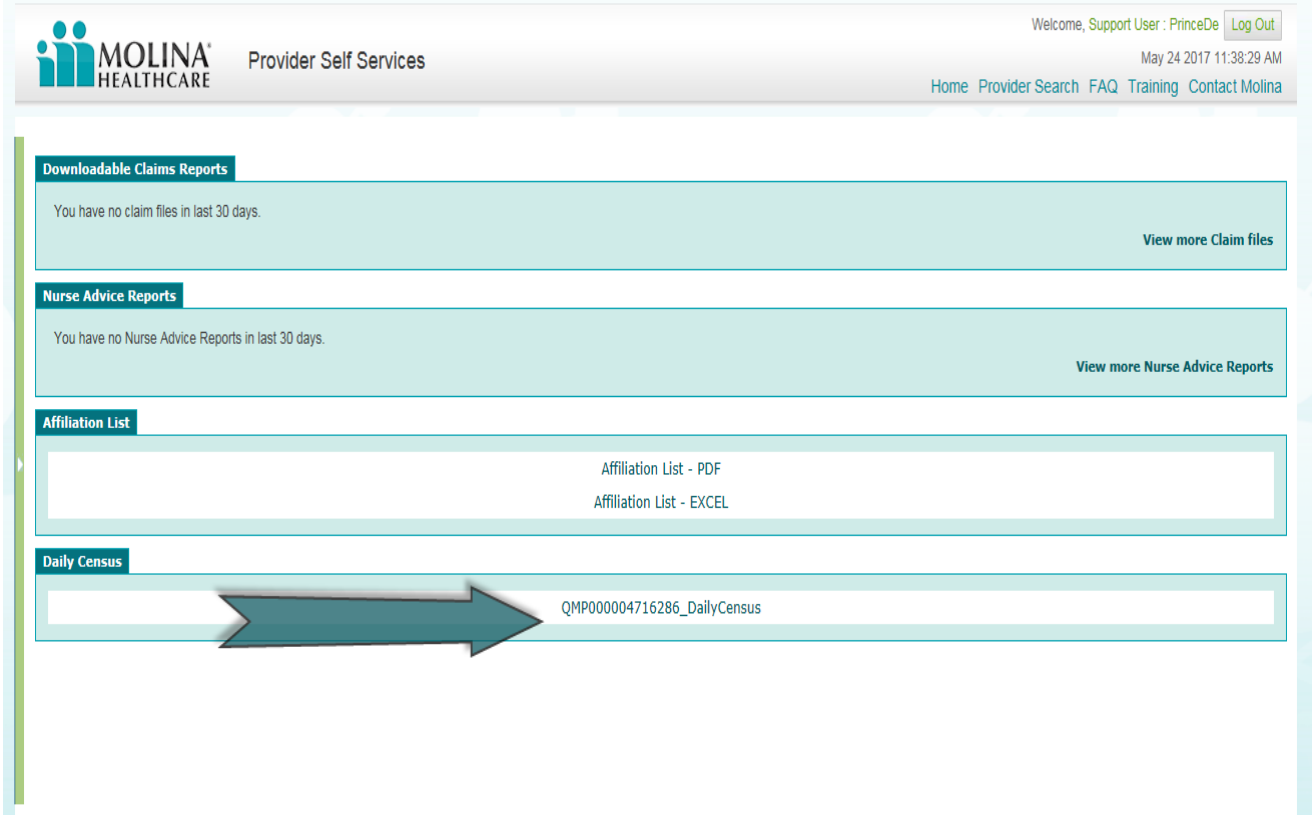
Accessing the Molina Portal MESAV

- Then, select “Daily Census”



MOLINA HEALTHCARE
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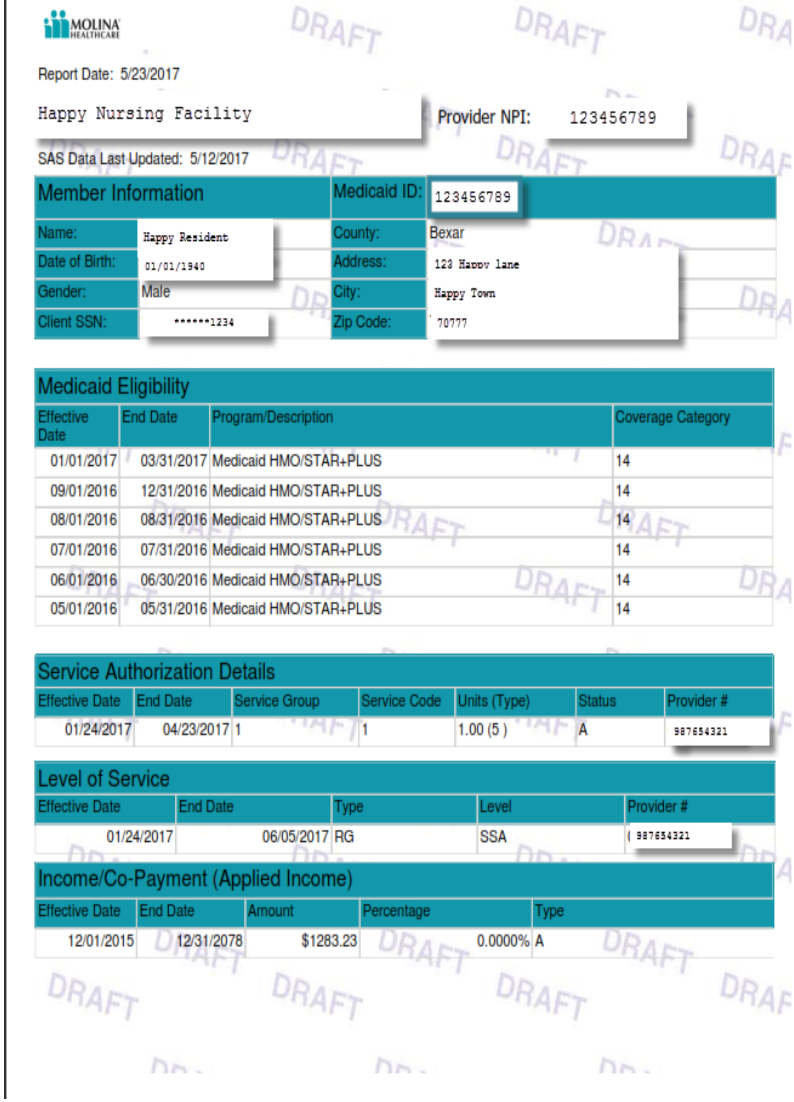
Viewing the Molina Portal MESAV



MOLINA HEALTHCARE

Report Date: 5/23/2017

Happy Nursing Facility | Provider NPI: 123456789

SAS Data Last Updated: 5/12/2017

Member Information | Medicaid ID: 123456789

Name:	Happy Resident	County:	Bexar
Date of Birth:	01/01/1940	Address:	123 Happy lane
Gender:	Male	City:	Happy Town
Client SSN:	******1234	Zip Code:	70777

Medicaid Eligibility

Effective Date	End Date	Program/Description	Coverage Category
01/01/2017	03/31/2017	Medicaid HMO/STAR+PLUS	14
09/01/2016	12/31/2016	Medicaid HMO/STAR+PLUS	14
08/01/2016	08/31/2016	Medicaid HMO/STAR+PLUS	14
07/01/2016	07/31/2016	Medicaid HMO/STAR+PLUS	14
06/01/2016	06/30/2016	Medicaid HMO/STAR+PLUS	14
05/01/2016	05/31/2016	Medicaid HMO/STAR+PLUS	14

Service Authorization Details

Effective Date	End Date	Service Group	Service Code	Units (Type)	Status	Provider #
01/24/2017	04/23/2017	1	1	1.00 (5)	A	987654321

Level of Service

Effective Date	End Date	Type	Level	Provider #
01/24/2017	06/05/2017	RG	SSA	987654321

Income/Co-Payment (Applied Income)

Effective Date	End Date	Amount	Percentage	Type
12/01/2015	12/31/2078	$1283.23	0.0000%	A

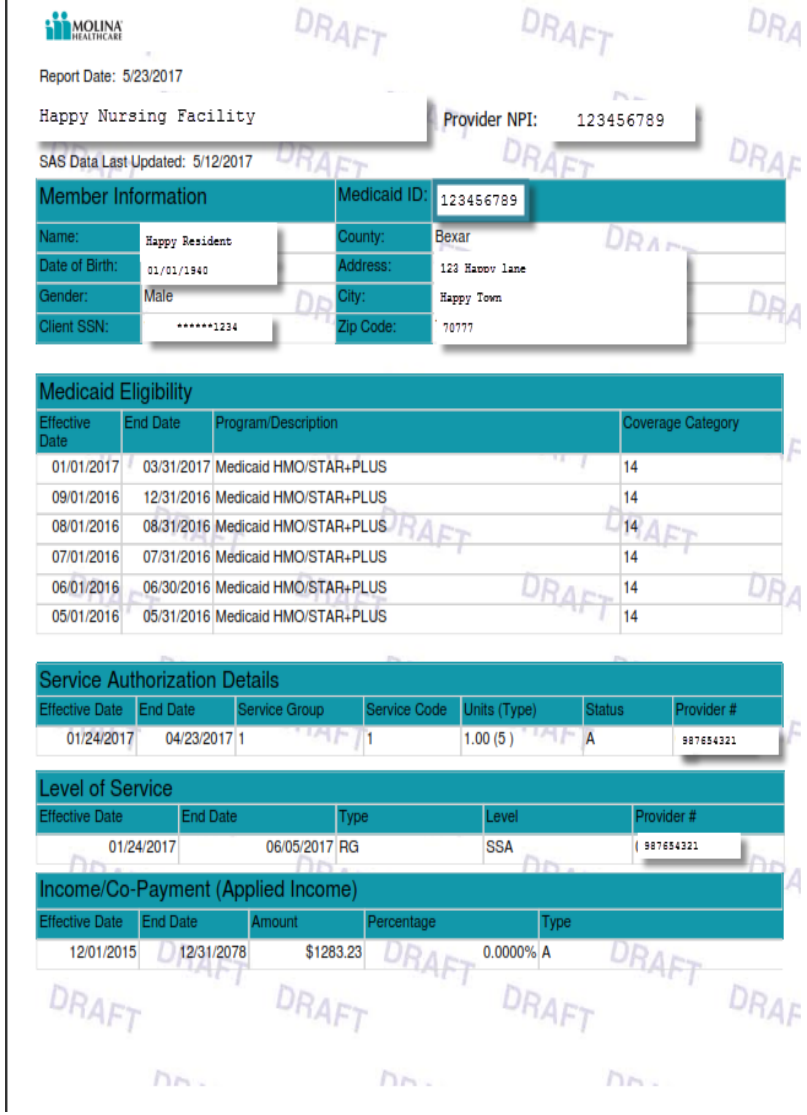
The MESAV will appear as a PDF file and will include:

- All MESAVs associated with the same provider number
  - This will include past, current and discharged residents
- All information associated with MESAV data including eligibility, service authorization, level of care and applied income
- The service authorization will display the difference between coinsurance (service code 3) and daily care (service code 1)

MOLINA HEALTHCARE

Your Extended Family

Navigating the Molina Portal MESAV



MOLINA HEALTHCARE

Report Date: 5/23/2017

Happy Nursing Facility — Provider NPI: 123456789

SAS Data Last Updated: 5/12/2017

Member Information — Medicaid ID: 123456789

Name:	Happy Resident	County:	Bexar
Date of Birth:	01/01/1940	Address:	123 Happy lane
Gender:	Male	City:	Happy Town
Client SSN:	******1234	Zip Code:	70777

Medicaid Eligibility

Effective Date	End Date	Program/Description	Coverage Category
01/01/2017	03/31/2017	Medicaid HMO/STAR+PLUS	14
09/01/2016	12/31/2016	Medicaid HMO/STAR+PLUS	14
08/01/2016	08/31/2016	Medicaid HMO/STAR+PLUS	14
07/01/2016	07/31/2016	Medicaid HMO/STAR+PLUS	14
06/01/2016	06/30/2016	Medicaid HMO/STAR+PLUS	14
05/01/2016	05/31/2016	Medicaid HMO/STAR+PLUS	14

Service Authorization Details

Effective Date	End Date	Service Group	Service Code	Units (Type)	Status	Provider #
01/24/2017	04/23/2017	1	1	1.00 (5)	A	987654321

Level of Service

Effective Date	End Date	Type	Level	Provider #
01/24/2017	06/05/2017	RG	SSA	987654321

Income/Co-Payment (Applied Income)

Effective Date	End Date	Amount	Percentage	Type
12/01/2015	12/31/2078	$1283.23	0.0000%	A

To navigate the MESAV file

- Scroll up or down OR
- Utilize the *Control F* feature on you keyboard to search for an individual record
  - Hold down ***"Ctrl "*** key and ***"F "*** key simultaneously
  - Enter a single identifier in the text box
    - Last Name
    - First Name
    - Medicaid ID
  - Select ***"Enter"***
  - If multiple records exist with the same identifier, select ***"Find Next"*** until desired record is located

MOLINA HEALTHCARE

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Printing the Molina Portal MESAV

Printing the entire MESAV file

- Select “Print”
- Follow printing prompts per your system
- NOTE: This could result in the printing of hundreds of pages

Printing Individual MESAV

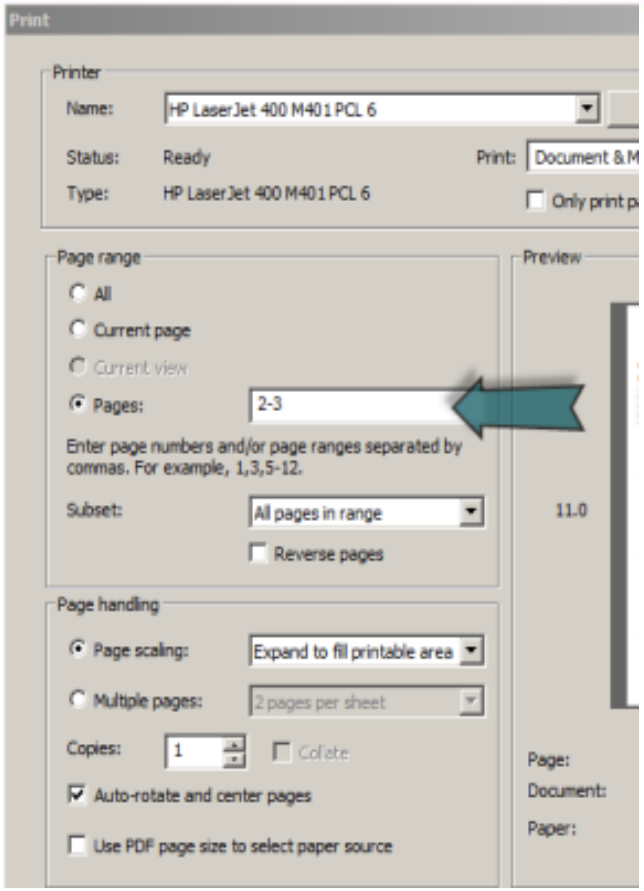
- Use the print screen feature

OR

- Use the Snipping Tool (if available on your system)

OR

- Select “Print”
  - Use the page number feature in the print command screen (as shown right)



When printing files, all HIPAA security guidelines must be adhered to per state and federal regulations

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Downloading the Molina Portal MESAV

Downloading the MESAV file

- Entire PDF file can be downloaded and saved to your computer
- Follow your operating system download process

OR

- Select “File”
- Select “Save As”
  - Be sure to note what location on your computer the file will be saved to
- Name the file
- Select “Save”

When downloading files, all HIPAA security guidelines must be adhered to per state and federal regulations

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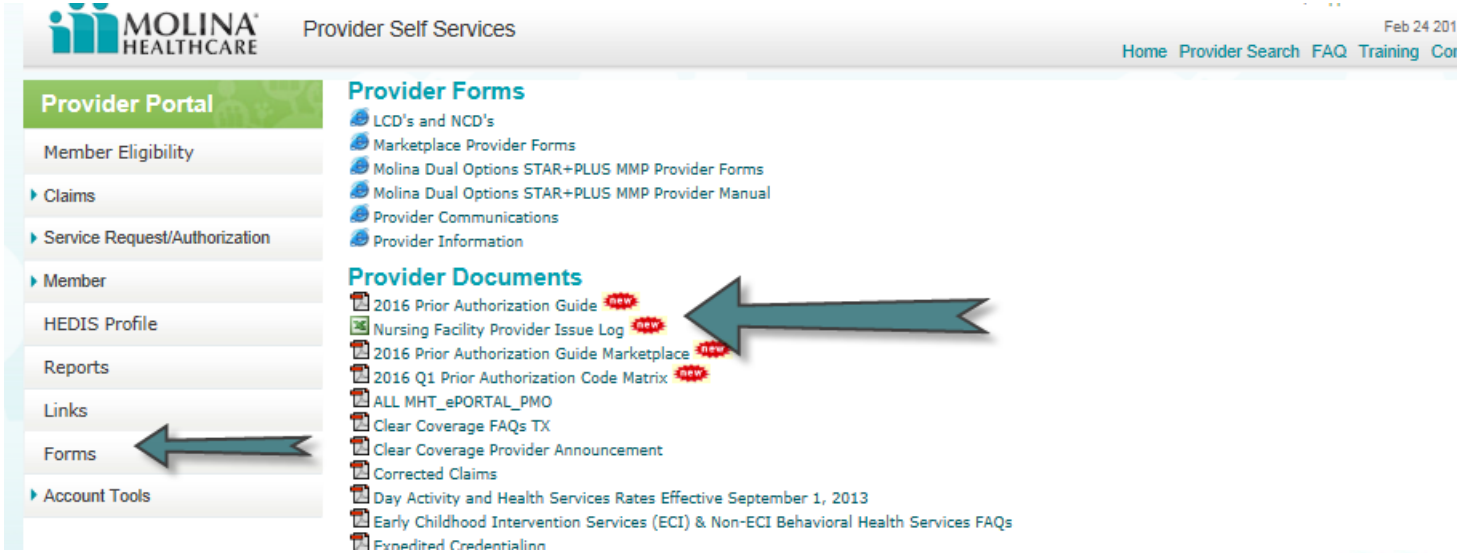
Molina NF Provider Issue Log

If there is an question on a claim that needs further review, the Nursing Facility Provider Issue Log should be completed and emailed to the assigned Provider Service Rep (PSR) for assistance.

- For an electronic version of the NF Provider Issue Log contact your assigned PSR
- The NF Provider Issue Log can downloaded from the Molina E-Portal



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Molina NF Provider Issue Log

MOLINA HEALTHCARE

Nursing Facility Provider Issues Log

One Nursing Facility per form

Date:

Facility Representa

Email Address:

Provider Name:

Tax ID:

NPI:

TX Provider # (Medicaid On

Member Last Name	Member First Name	Member ID	Dates of service from	Dates of service to	Type of Claim (Select One)	Issue (Select One)	Date of service authorization	Date of level of care on MESAV	Claim Number	Facility Comments	PSR Response

If this is a Medicaid Claim
Please attach MESAV

If this is a MMP Claim
Please attach Common Working File

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Additional Resources

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Molina Quality Living Program 2017 (MQL)

Designed to reward and encourage quality in Texas Nursing Facilities

Total Payout since March 1, 2015

$1,705,000.00

- Average annual payout per qualifying Nursing Facility $16,234
- Average payment per member per month in each qualifying Nursing Facility $40.00
- For more information email: NFProviderServices@Molinahealthcare.com

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Molina Quality Living Program 2017 (MQL)

The Molina Quality Living - A Program Summary

Molina Healthcare of Texas is offering the Molina Quality Living Program (MQL Program) to reward quality and efficiency for Nursing Facilities (NFs) that meet or exceed specific performance criteria in the provision of residential/custodial nursing facility care to Molina members. Based on the level of quality provided to Texas residents, Molina will invite Nursing Facilities to participate and benefit from the program features offered by Molina Healthcare of Texas. ***Please Note – Providers are prohibited from influencing MCO selection.***

	PLATINUM Facility	GOLD Facility	SILVER Facility
Recognition Criteria			
Demonstrated Quality	Achieved 5 out of 5 STARS	Achieved 5 out of 5 STARS	Achieved 4 out of 5 STARS
Molina Residents	40 or more NF residents that are Molina Healthcare Members	20 or more NF residents that are Molina Healthcare Members	20 or more NF residents that are Molina Healthcare Members
Program Features			
Pay-For-Quality	$10 Per Resident Per Month for EACH measure achieved of the 7 quality measures – Details on reverse (Nursing Facility can earn ***up to an additional $70 Per Resident Per Month*** if all 7 measures are achieved)		
Awardee Plaque & Website Recognition	"MQL Platinum Facility" plaque Molina Healthcare Website recognition	"MQL Gold Facility" plaque Molina Healthcare Website recognition	"MQL Silver Facility" plaque Molina Healthcare Website recognition
Molina Sponsored Activities	1 Activity EVERY MONTH	1 Activity Every Other Month	1 Activity Every Quarter
Supplies Assistance	$500 per quarter for facility equipment available to all residents	$250 per quarter for facility equipment available to all residents	$250 per quarter for facility equipment available to all residents
Value Added Services for Molina Members	➢ Personal blanket (or equivalent) for new members ➢ Skid proof socks for new members ➢ Accessory tote bag (one time) for new members		
VIP Molina Servicing	➢ Designated Molina LTC Provider Services Representative AND Molina Activities Coordinator ➢ Designated Molina Service Coordinator to assist residents with their needs		
Additional Financial Benefits	One-time cash deposit equivalent to the average monthly billables (If desired by Facility – no reconciliation necessary)		

Molina Quality Living Program 2017 (MQL)

Molina Quality Living Pay-For-Quality (P4Q) Program

As a Molina Quality Living Program participant at the Platinum, Gold or Silver level, Molina will offer a P4Q program where Molina Quality Living providers will be eligible to receive ***up to an additional $70 Per Resident Per Month*** for meeting or exceeding quality and performance measure thresholds in various categories.

Quality Measures – Nursing Facilities will be scored on quality measures as reported on the most current CMS Minimum Data Set version 3.0 (MDS 3.0) standardized assessment, which is available on the Medicare Nursing Home Compare website. If the NF meets or exceeds the National Average score AND the Texas Average score, the NF will earn ***additional payment of $10 Per Resident Per Month***.

Quality Measures	Standard	Additional Payment
% of Long-stay High-Risk Residents with pressure ulcers	Meet or exceed the National Average score AND the Texas Average score	$10.00 PRPM
% of Long-stay Residents who self-report moderate to severe pain		$10.00 PRPM
% of Long-stay Residents whose need for help with daily activities has increased		$10.00 PRPM
% of Long-stay Residents assessed and given, appropriately, the pneumococcal vaccination		$10.00 PRPM
% of Long-stay Residents assessed and given, appropriately, the seasonal influenza vaccine		$10.00 PRPM
% of short-stay Residents who were re-hospitalized after a nursing home admission		$10.00 PRPM
% of short-stay Residents who have had an outpatient emergency department visit		$10.00 PRPM
TOTAL Additional Payment Opportunity	**Paid Quarterly on a Per Resident Per Month Basis**	**Up to $70.00 PRPM**

Electronic Funds Transfer & Remittance Advice (EFT & ERA)

Molina Healthcare has partnered with our payment vendor, Change Healthcare ProviderNet, for Electronic Funds Transfer and Electronic Remittance Advice. Access to the Change Healthcare 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 Change Healthcare ProviderNet at: (877) 389-1160 or email: wco.provider.registration@changehealthcare.com

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Grievances and Appeals

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

- **Grievance** -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.
- **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.

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State Fair Hearing Information

- If a Member disagrees with the health plan's decision, the Member has the right to ask for a fair hearing.
- The Member may name someone to represent him or her by writing a letter
- A provider may be the Member's representative.
- The Member or the Member's representative must ask for the fair hearing within 90 days of the date on the health plan's letter that tells of the decision being challenged.
  - If the Member does not ask for the fair hearing within 90 days, the Member may lose or her right to a fair hearing.
- If the Member asks for a fair hearing within 10 days from the time the Member gets the hearing notice from the health plan, the Member has the right to keep getting any service the health plan denied, at least until the final hearing decision is made. If the Member does not request a fair hearing within 10 days from the time the Member gets the hearing notice, the service the health plan denied will be stopped.
- If the Member asks for a fair hearing, the Member will get a packet of information letting the Member know the date, time, and location of the hearing. Most fair hearings are held by telephone. At that time, the Member or the Member's representative can tell why the Member needs the service the health plan denied.
- HHSC will give the Member a final decision within 90 days from the date the Member asked for the hearing.
- To ask for a fair hearing, the Member or the Member's representative should either send a letter to the health plan at P.O. Box 165089, Irving, TX 75016 or call (877)-319-6826.

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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)

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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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Molina Web Resources

www.Molinahealthcare.com

Nursing Facilities Partners in Care Spring 2015 Newsletter

- Common Reasons for NF Claims Denials

http://www.molinahealthcare.com/providers/tx/medicaid/comm/PDF/TX-medicaid-provider-newsletter-spring-2015.pdf

Nursing Facilities Partners in Care Fall/Winter 2015 Newsletter

- Common Reasons for NF Claims Denials
- Correcting Denied Claims in the Molina E-Portal
- Claims Report in Excel
- NF Provider Issue Log
- NOMNC Process
- Non-Emergency Ambulance Transportation Authorizations

http://www.molinahealthcare.com/providers/tx/medicaid/comm/PDF/Nursing-Facility-Fall-2015.pdf

Nursing Facilities Partners in Care Fall 2016 Newsletter

- Prior Authorization – SNF and Therapy
- Market Place Plans
- Electronic Funds Transfer (EFT)
- “Money Follows the Person” program (MFP)
- Claim Tid-Bits
- Claim Correction Tips
- Claim Appeals

http://www.molinahealthcare.com/providers/tx/medicaid/comm/PDF/Fall-Newsletter-2016.pdf

Molina Web Resources

www.Molinahealthcare.com

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

Add On Therapy Services (formerly known as Goal Directed Therapy) Prior Authorization and Claim Filing Process
http://www.molinahealthcare.com/providers/tx/PDF/Medicaid/Nursing-Facility-STAR-PLUS-Add-on-therapy-prior-authorization-and-claim-filing-process.pdf

Prior Authorization Guide/Form
http://www.molinahealthcare.com/providers/tx/medicaid/forms/PDF/MHT-Prior-Auth-Guide-Q1-2017.pdf

http://www.molinahealthcare.com/providers/tx/medicaid/forms/PDF/2017-MHT-PA-Code-Matrix-Q1-1-1-17.pdf

Behavioral Heath Prior Authorization Form
http://www.molinahealthcare.com/providers/tx/medicaid/forms/PDF/ Behavioral-Health-Prior-Authorization-Form.pdf

NF Explanation of Payment Guide
http://www.molinahealthcare.com/providers/tx/PDF/Medicaid/nursing-facility-explanation-of-payment-guide.pdf

NF Provider Manual
http://www.molinahealthcare.com/providers/tx/medicaid/manual/PDF/Provider-Manual-Nursing-Facility.pdf

Molina Web Resources

www.Molinahealthcare.com

NF Provider Orientation – STAR+PLUS
http://www.molinahealthcare.com/providers/tx/medicaid/comm/PDF/Provider-Orientation-STARPLUS-Nursing-Facility.pdf

NF Provider Orientation – MMP (Medicare Medicaid Program)
http://www.molinahealthcare.com/providers/tx/PDF/Medicaid/nursing-facility-medicare-medicaid-plan-provider-training.pdf

HHSC Guidance on NF Non-Emergency Transportation (9/4/15)
https://hhs.texas.gov/services/health/medicaid-and-chip/provider-information/contracts-and-manuals/texas-medicaid-and-chip-uniform-managed-care-manual

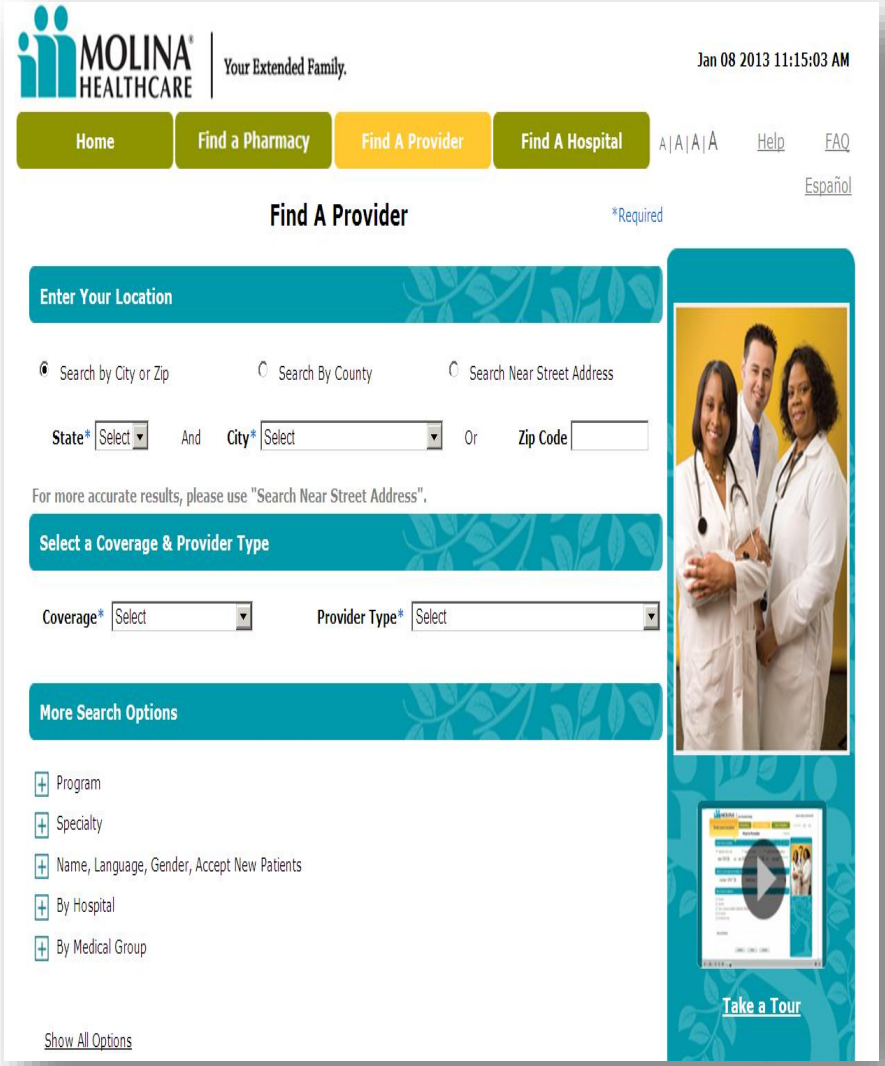
HHSC regarding CPWC
https://hhs.texas.gov/sites/hhs/files//documents/laws-regulations/handbooks/sph/policy-updates/16-04-11_003.pdf

The Molina "Contract Request Form"
http://www.molinahealthcare.com/providers/tx/medicaid/forms/PDF/33216_TX_%20Medicaid_Contract_Request_Form_Final.pdf

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, https://providersearch.molinahealthcare.com/Provider/ProviderSearch?RedirectFrom=MolinaStaticWeb and select *Find a Provider*, *Find a Hospital*, or *Find a Pharmacy*.



Questions and Comments

NFProviderServices@Molinahealthcare.com

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