Q. **Who should providers contact to verify membership or benefit eligibility?**

A. Providers should contact Member Services at 888-898-7969 to verify member and benefit eligibility. Follow the prompts to verify eligibility via Interactive Voice Response (IVR) or to speak to a representative. Member eligibility is also available on the Molina Web Portal.

Q. **What number is used for members to contact for transportation?**

A. Members should contact Member Services at 888-898-7969 option 2, and then option 3.

Q. **How much notice is required for member transportation requests?**

A. Transportation to scheduled office visits should be requested at least three business days prior to the visit through Member Services at 888-898-7969 option 2, then option 3.

Q. **What is the member’s Behavioral Health benefit period?**

A. Benefits are administered on a calendar year basis, from January through December each year.

Q. **What services require Prior Authorization?**

A. Prior authorization is required for the following Behavioral Health services:
   - Medicare: Inpatient, Partial Hospitalization, Day Treatment, and Intensive Outpatient Programs (IOP)
   - Medicare and Medicaid: Electroconvulsive Therapy (ECT), Psychological Testing, and > 12 office visits/year for adults and >20 office visits/year for children

Q. **What is the reimbursement for the providers that render services to the Molina members?**

A. The reimbursement is based on the provider contract with Molina.
Q. How many Behavioral Health visits per year is the member entitled to receive?

A. For Medicaid, the outpatient behavioral health benefit is currently 20 visits per calendar year. For Medicare, there is no limit for outpatient visits for behavioral health or substance abuse. There are certain lifetime limitations for Medicare for inpatient services. All services must meet medical necessity guidelines.

Q. For 2012, do only visits after July 1 count toward the Medicaid 20-visit limit?

A. For 2012, there will be a combination of visits received in 2012 under the CompCare program combined with visits after July 1 for Medicaid members. CompCare information was loaded into the Molina system based on data pulled from the CompCare system on June 18, 2012 for Medicaid members only. No CompCare data was converted for Medicare members and their services will start counting from July 1 forward only. If you have a question as to whether a person is nearing their 20 visits or requires an authorization, please contact Member Services at 888-898-7969, Option 1, then Option 1.

Q. How do I become a Behavioral Health provider in the Molina Network?

A. Contact Molina at 866-449-6828 x 155822 or send a request to MHMProviderContractingMailbox@molinahealthcare.com.

Q. How long can members continue to be seen by non-contracted providers?

A. Molina will allow members to continue seeing their current providers for a 90-day transition of care time period. Providers should contact Molina Provider Contracting to ensure contracting is complete prior to the end of the 90-day transition period.

Members seeing non-contracted providers at the end of the transition period (9/30/2012) will be required to see contracted providers.

Q. Is Molina 5010 compliant?

A. Yes, Molina is compliant with the HIPAA 5010 electronic transaction standards.

Q. Would multiple services provided on the same date of service be considered as one visit or counted as individual visits?

A. Each claim submitted by a provider is counted towards the benefit limit. For example, if one provider performed two services on the same day/same claim, this would count as one visit toward the benefit. If two different providers saw the
member on the same day, billed on two claims, this would count as two visits toward the benefit limit.

Q. Will medication management count towards the 20 Medicaid visits?
A. Yes, medication management visits performed by a behavioral health provider will count towards the 20 outpatient visit limit for Medicaid.

Q. Will Molina provide a retro authorization? What is the procedure?
A. Providers should confirm with Member Services whether authorization is needed prior to the member’s visit whenever possible. In rare occurrences when authorization cannot be obtained prior to service, provider should submit the request by the next business day after the service, documenting the reasons for the retro authorization request.

Failure to obtain authorization for a service that requires authorization will result in an administrative denial.

Q. Will lifetime days accumulated during the beneficiary’s enrollment with original Medicare be counted by Molina towards the lifetime day limit?
A. No, Molina will count lifetime days effective 7/1/2012 and going forward for Molina Medicare members. Days incurred prior to this date will not be counted toward the lifetime limit.

Q. After the Medicaid member has used their 20 outpatient visits, will the patient automatically be referred to Community Mental Health?
A. No, the patient will not automatically be referred. If additional care is required for services beyond the 20 Medicaid visits, coordination needs to occur between the Behavioral Health provider and Community Mental Health. Molina Utilization Management Department is available to assist with this process.

Q. If, during the course of treatment, a Medicaid member is determined to have Serious and Persistent Mental Illness, what steps should be taken to coordinate care with Community Mental Health?
A. If the patient is identified as having Serious and Persistent Mental Illness at any time during the treatment period, coordination needs to occur between the Behavioral Health provider and Community Mental Health. Molina Utilization Management Department is available to assist with this process.
Q. **Do you have a credentialing grid?**
A. Providers will be credentialed according to NCQA guidelines.

Q. **Does Molina pay an in-home benefit?**
A. Molina will pay providers for in-home visits, subject to prior authorization requirements and appropriate billing in accordance with state Medicaid and federal CMS guidelines.

Q. **Are Medicare members limited to 20 visits?**
A. No. Member outpatient benefit does not have a visit limitation, but is subject to Molina authorization guidelines and must meet medical necessity guidelines.

Q. **If a provider is not certified to perform Medicare services, and the member is a dual eligible, how should the claim be billed to Molina Medicaid?**
A. If the member is a Molina Medicare member, please file the claim with Molina Medicare. Molina will deny the claim under Medicare and process a secondary claim under Medicaid. If the member is not Molina Medicare, the provider should submit the claim to Medicare first and then to Molina Medicaid along with evidence of Medicare denial of service.

Q. **If a member has Molina Medicare and Molina Medicaid, does the provider need to bill claims separately for each product?**
A. No, Molina Medicare benefits are primary and the claim only needs to be billed to Molina Medicare. The claim will automatically be passed within the Molina system to Molina Medicaid for secondary payment.

Q. **Does Molina accept secondary claims via electronic submission?**
A. Yes.

Q. **Does a Provider Change form need to be submitted when a contracted entity needs to remove a provider?**
A. Yes. Please submit those changes to the Provider Change Form mail box at [MHMProviderChangeForm@molinahealthcare.com](mailto:MHMProviderChangeForm@molinahealthcare.com)
Q: How does a contracted group add new providers?

A. Submit providers Name, Title, Specialty & CAQH number in writing to the Provider Service mail box at MHMProviderContractingMailbox@molinahealthcare.com