April 13, 2022

Provider Memorandum

MLTSS Enrollee Identification and Billing Guidelines

Molina Healthcare of Illinois (Molina) supports providers with important information and reminders. Use this guide for identifying and billing for dual-eligible beneficiaries enrolled in/covered under Medicaid Managed Long-Term Services and Supports (MLTSS).

Note: Depending on the service provided and each enrollee's program, providers must bill either the HealthChoice Illinois MLTSS Managed Care Organization (MCO), Medicare, or Medicaid Fee-For-Service (FFS).

MLTSS Eligibility

Dual-eligible (MMP) enrollees are individuals who qualify for full Medicare **and** full Medicaid benefits. However, MLTSS enrollees are those individuals who have dual eligibility, are **not** participating in the Medicare Medicaid Program (MMP), reside in a nursing facility or Supportive-Living Facility (SLF), or are on one of the following Home and Community Based Services (HCBS) waivers:

- Persons with Disabilities
- Persons with HIV or AIDS
- Persons with Brain Injury
- Persons who are Elderly

How to Identify MLTSS Coverage

Providers can use our Availity Provider Portal and the state's Medical Electronic Data Interchange (MEDI) system to review eligibility status and MCO designation for their patients to aid in submitting claims. In MEDI, MLTSS enrollees are identified with an Exclusion Code of "6" and a "Special Information" message underneath the "End Date" and "City – State – Zip" line with the following message:

> "Medicare is primary payer. Medicaid MCO covers LTC, HCBS waiver services (excluding DD waivers), non-Medicare behavioral health, and non-emergency transportation. Medicaid FFS covers Medicare crossovers and other services not covered by Medicare or the MCO."

Who Should I Bill—Medicare, Medicaid FFS, or the Medicaid MCO?

Medicare remains the primary payer for dual-eligible beneficiaries **enrolled in MLTSS**. Use these helpful tips when submitting claims:

- Medicare-covered services **must** be billed to the patient's Medicare carrier.

- Non-Medicare covered Long-Term Care services (LTC), Home and Community-Based Waiver Services (HCBS), non-Medicare Behavioral Health services, and non-emergency transportation services **must** be billed to the Medicaid MLTSS MCO (i.e., Molina).
- All other non-Medicare covered services covered by Medicaid (e.g., non-Medicare Durable Medical Equipment (DME), prescription drugs, inpatient hospital, dental services, vision services, Medicare rollover services, etc.) should be billed to Medicaid FFS unless they are covered as part of an LTC facility per diem.
- Claims questions or appeals should be sent to the entity responsible for covering the service (Medicare, Medicaid FFS, or Molina).

Questions?

We're here to help. Contact your Provider Network Manager or email the Provider Network Management team at MHILProviderNetworkManagement@MolinaHealthcare.com. For help identifying your Provider Network Manager, visit Molina's Service Area page at MolinaHealthcare.com.

Availity Provider Portal

We continue our transition to the Molina Availity Provider Portal, a tool that streamlines your claims management, authorizations, and eligibility/benefit verification. Are you registered? Click here.

Get Critical Updates

Receive news and updates about Molina services and plan requirements delivered straight to your inbox! Click here to join Molina's provider email list.

Note: Molina's website and documents are best viewed in Google Chrome or Microsoft Edge.