Provider Education Training

February 2021

VA-ALL-PRV-20060-21

MOLINA® HEALTHCARE

Agenda

- Introduction to MCC
- Claims and billing
- Electronic Funds Transfer (EFT)
- Provider portal
- Authorization information
- Appeals & grievances
- Compliance and integrity
- MCC of VA (HMO SNP)
- General Information / Q&A

zoom etiquette

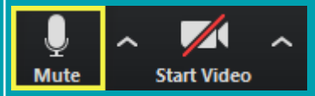
Link Participant ID with Audio

If your Participant ID has not been entered, dial #ParticipantID#.

EXAMPLE: Participant ID is 16, then enter #16#.

Mute your line

UNMUTED



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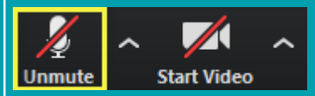
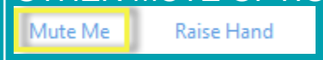


OTHER MUTE OPTIONS



Raise your hand with questions

CLICK the Raise Hand button. The presenter will be notified that you have a question.

MOLINA HEALTHCARE

Molina Complete Care's Mission

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

Introductions

Customer Service

- CCC Plus: 1-800-424-4524
- Medallion 4.0: 1-800-424-4518

Please reach out to us anytime. We’re here to assist you any way we can.

MCC Network Contact Information for Medical Services

MCC Provider Network Department

CCC Plus	1-800-424-4524 (TTY 711)
Network email	MCCVA-Provider@molinahealthcare.com
Network fax	1-888-656-5098
Medallion 4.0	1-800-424-4518 (TTY 711)
Roster submission email	MCCVA-Providerroster@molinahealthcare.com
MCC website	www.mccofva.com

MCC Customer Service

CCC Plus Plan	1-800-424-4524 (TTY 711)
CCC Plus email	MCCVA-CCCPlus@molinahealthcare.com
Medallion 4.0	1-800-424-4518 (TTY 711)
Medallion email	MCCVA-Medallion4.0@molinahealthcare.com

MCC Network Contact Information for Behavioral Health Services

MCC Provider Network Department

CCC Plus	1-800-424-4524 (TTY 711)
Network email	MCCVA-Provider@molinahealthcare.com
Network fax	1-888-656-1409
Medallion 4.0	1-800-424-4518 (TTY 711)
Roster submission email	MCCVA-Providerroster@molinahealthcare.com
MCC website	www.mccofva.com

MCC Customer Service

CCC Plus Plan	1-800-424-4524 (TTY 711)
CCC Plus email	MCCVA-CCCPlus@molinahealthcare.com
Medallion 4.0	1-800-424-4518 (TTY 711)
Medallion email	MCCVA-Medallion4.0@molinahealthcare.com

Claims Submission and Reimbursement

Electronic Data Interchange (EDI) and Paper Claims Submission Information

- We strongly encourage all providers to submit claims electronically to MCC. EDI streamlines the submission process and can expedite receipt and payment for covered services provided to our members
- Paper submissions and/or claims requiring supporting documentation can also be submitted by U.S. mail
- We also offer an electronic funds transfer (EFT) option to our participating providers who register for EFT via our provider portal

Electronic claims submission

- EDI clearing houses:
  - Availity
  - Office Ally
  - Trizetto Provider Solutions
- Payer ID: MCCVA

Paper claims submission

Molina Complete Care
Claims Service Center
1 Cameron Hill Circle, Ste. 52
Chattanooga, TN 37402

Electronic funds transfer

Enrollment information via provider portal: www.mccofva.com, or email us at MCCVA-Provider@molinahealthcare.com

Advantages of Electronic (EDI) Claims

What's in it for providers?

- Improved efficiency
  - No paper claims. No envelopes. No stamps
  - Prompt confirmation of receipt or incomplete claim
  - Reduced administrative costs
  - Less paper storage
- Improved quality
  - Up-front electronic review ensures higher percentage of clean claims
  - Claims do not need to be re-keyed from paper claim, eliminating human error
  - Errors are quickly identified
  - Secure process with encryption keys, passwords, etc.
- Faster reimbursement

Tips for Filing a Clean Claim

- DO:
  - Give complete information on the member and policy holder
  - Give complete information on you, the provider
  - Include any other carrier’s payment information
  - Include the complete, HIPAA-compliant diagnosis
  - Obtain authorization for services
  - Show your entire charge
  - Include appropriate billing modifier (where applicable)
  - Submit your claims electronically and within timely filing guidelines
  - Monitor your EDI transaction reports
  - Include accurate rendering provider and NPI number
  - Attach the primary carrier’s explanation of benefits (EOB)
- DO NOT:
  - Use invalid procedure or diagnosis codes
  - Forget to include the authorization number
  - Omit information on the claim because you have already provided it on the treatment plan
  - Forget the place of service code

Please note: incomplete forms will delay processing

Standard Code Sets, Claim Forms and Data Elements

MCC requires providers to use the following standard code sets (and successor code sets when published, upon their effective dates) on both paper and electronic claim transactions

- HIPAA specifically identifies the following procedure and diagnostic code sets as standard:
  - ICD-10-CM
  - CPT®-4 and modifiers
  - HCPCS level II and modifiers
  - Revenue codes
  - Place of service codes
  - Type of bill codes

- Use current, standard HIPAA compliant codes
- Reference the most recent copy of MCC's Universal Services List (USL) for standard codes for most facility and program services
- Submit paper and EDI claims on complete CMS 1500 forms for professional services or UB-04/CMS 1450 forms for institutional services.
- Include the member's Medicaid Identification (ID) number and/or the MCC ID number
- Include the NPI

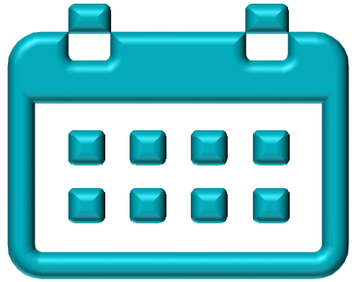
National Provider Identifier (NPI) and Tax Identification Number (TIN)

- The NPI is a 10-digit identifier required on all HIPAA standard electronic transactions (also required for billing on paper claim forms)
- Paper claim forms and electronic claim files contain fields in which to enter NPIs for the “rendering provider” and the “pay to/billing provider”
- Paper and electronic claims must include the provider’s TIN, Social Security Number (SSN), and NPI
- The NPI is for identification purposes, while the TIN/SSN is for tax purposes
- For organizations, please use the organization NPI in the rendering and pay to provider fields (this excludes inpatient facilities who bill on the UB-04 form and require an attending physician)
- For groups, please use the individual NPI in the rendering provider field and the group NPI in the pay to provider field

Important: Claims that do not include a TIN/SSN will be rejected

Timely Filing and Payment Timeframes

- MCC commits to the timely processing of claims for covered services provided to our members
- We have established guidelines and infrastructure that ensures timely processing and payment within both federal and state guidelines
- Clean claims for covered services must be received no later than one hundred and eighty (180) days from the date of services to ensure



Timely Filing and Payment Timeframes (continued)

- Processing and payment for covered services are generally made within 30 days upon receipt of clean claim and any required supporting documentation
- Processing and payment for clean claims for Nursing Facilities, LTSS (including when LTSS services are covered under ESPDT), ARTS and Early Intervention providers are processed within 14 calendar days of receipt
- Payment is made in accordance with the rate exhibit and terms of your provider agreement

Corrected claims are subject to a timely filing period equal in length to the initial timely filing period, starting from the first denial or most recent payment

Submission Order, Dual-Eligible Members and Coordination of Benefits

- Providers should follow traditional claims submission order in accordance with industry standard coordination of benefit rules
- Claims for services provided to members who have another primary insurance carrier must be submitted to the primary insurer first in order to obtain an explanation of benefits (EOB)
  - The full obligation of the primary insurer must be met before MCC can make a payment
- Unless the Medicare benefit limit is exhausted, please submit claims for Medicare-covered services rendered to dual-eligible members to Medicare

Submitting a Corrected Claim

- Corrected claims can be submitted electronically by selecting the appropriate data as shown below
- Corrected paper claims—paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated.
- Submit a new claim form with the correct data using the CMS-1500 claim form as follows:
  - Submit a frequency code “7” (replacement of prior claim) or “8” (void/cancel of prior claim) in the “resubmission code” field of block 22.
  - The claim number originally used by MCC to process the claim should be included in the “original ref/ no/” field of block 22
  - Failure to include the appropriate “resubmission code” and “original ref/ no/” in block 22 may result in a claim rejection or denial

Need assistance?
We can help!

MCC
Customer Service

CCC Plus: (800) 424-4524
Medallion 4.0: (800) 424-4518

Most Frequent Reasons for Claims Non-Payment

For your reference, the most frequent edits, or reasons for claims denial, include:

- Duplicate claim submission (i.e., the expense was previously considered)
- No preauthorization was obtained by the provider
- The member is ineligible, or coverage has lapsed
- Untimely claim submission/filing
- UB-04 claim does not follow correct coding requirements
- The primary insurance carrier’s explanation of benefits (EOB) or the member’s coordination of benefits (COB) form is needed
- The claim includes a non-covered diagnosis or service

Electronic Funds Transfer (EFT)

Enrolling in Electronic Funds Transfer (EFT)

- MCC accepts electronic funds transfer (EFT) enrollment through CAQH Enrollhub
- CAQH Enrollhub offers a universal enrollment tool for providers that provides a single point of entry for adopting EFT and ERA
- Enrollment information is available on the CAQH Enrollhub website at https://solutions.caqh.org.

Note: Vendor and MCC shall be bound by the National Automated Clearing House Association rules relating to corporate trade payment entries (the "Rules") in the administration of these ACH Credits.

The CAQH process facilitates compliance with the 2014 EFT/ERA Administrative Simplification mandate under the Affordable Care Act, eliminates administrative redundancies and creates significant time and cost savings

Using Electronic Funds Transfer

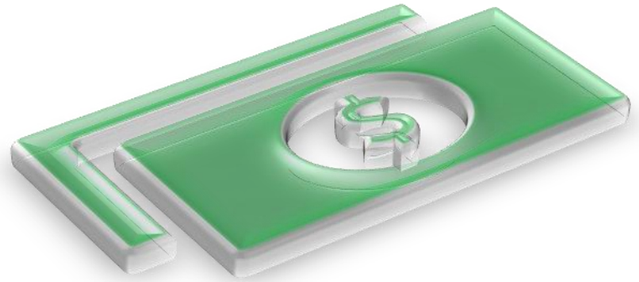
- Once you begin to receive EFT payments, you will no longer receive an Explanation of Payment (EOP) or Explanation of Benefits (EOB) by U.S. mail for those benefit plans that allow EFT
- Providers may access EOP or EOB information via the MCC provider portal at www.Availity.com
- Two ways to check EFT claim status:
  1. Use the Remittance Reviewer function within MCC's provider portal at www.Availity.com
  2. Review the electronic remittance advice (ERA) online through your clearinghouse UB-04 claim does not follow correct coding requirements
- Should a claim be denied, no payment will be due and there will be no EFT transaction. Please review the EOP or EOB online via www.Availity.com

Claims Check Cycle, EOPs and Remittances

- Upon receipt of a claim, MCC reviews the documentation and makes a payment determination
- As a result of this determination, a remittance advice, known as an Explanation of Payment (EOP) or Explanation of Benefits (EOB) is sent to the provider
- The Remittance Advice (EOP/EOB) includes details of payment or the denial
- It is important that you review all remittance advice promptly
- Check cycles occur once per week for payable claims. Electronic Funds Transfer (EFT) and paper check options are available
- You can review your remittance advice via our provider portal at www.Availity.com

MCC Encourages EFT

- Upon receipt of a claim, MCC reviews the documentation and makes a payment determination
- Providers can take advantage of MCC's online feature—Electronic Funds Transfer (EFT)—for claims payments. You can request to have certain claims payments directly deposited to your business bank account.
- EFT is quicker than the standard process of mailing and cashing or depositing a check, leaving you more time to devote to your practice
- EFT is available to organizations, group practices and individual providers who own the Taxpayer Identification Number (TIN) linked to the submitted claim
  - Individual providers within an organization or group practice are not able to receive EFT claims payment



MCC’s Provider Portal for Medical and Behavioral Health

Availity: MCC's Provider Portal Solution

Manage your MCC claims at www.Availity.com

Check member eligibility

Enter claims online

Check claim status

Print remittance advice

View remittance advice

View PCP rosters

MOLINA HEALTHCARE

Availity Provider Portal

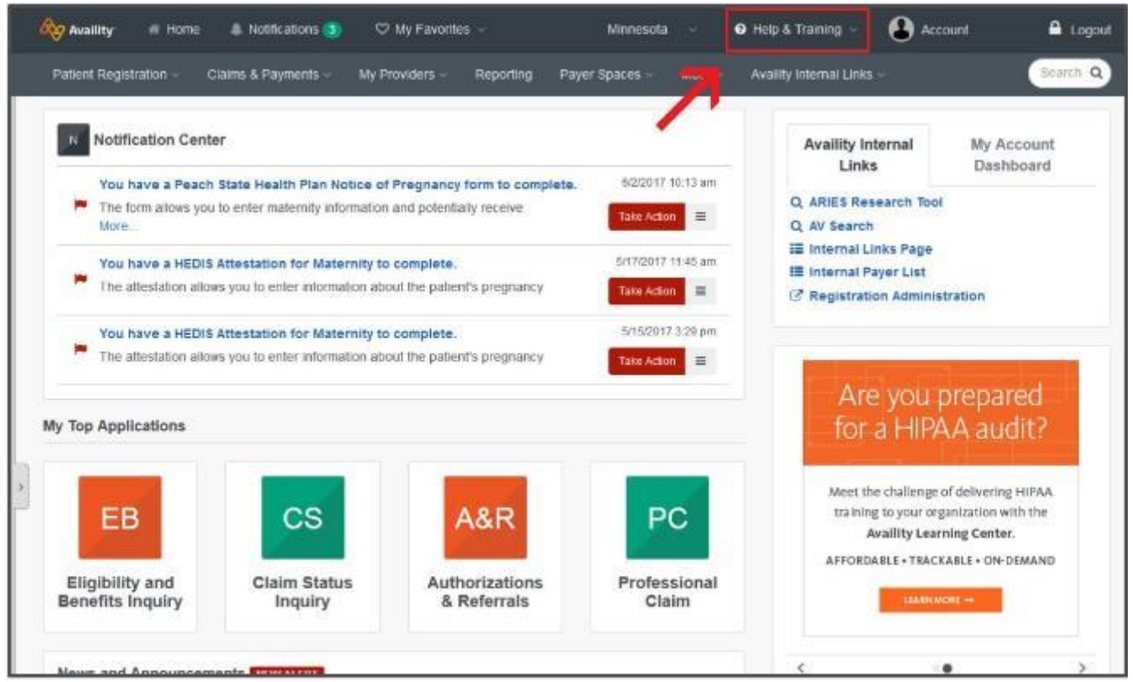
Availity Provider Registration

- Prepare
  - Your contact information
  - Your organization's contact information
  - National Provider Identifier (NPI)
  - Tax Identification Number (TIN)
- Register online at www.Availity.com
- Get on-demand video training

- Get support
  - Availity Customer Service Line: 1-800-282-4548
  - Open a support ticket online

Availity Provider Portal (continued)

- Availity provider portal on-demand video training



- Get on-demand video training by following these steps:

Help & Training → My Learning Plan → Select topics → Save topics → Click learning plan links → View on-demand → Navigate easily and quickly

Availity Provider Portal (continued)

Availity provider portal embedded demo videos

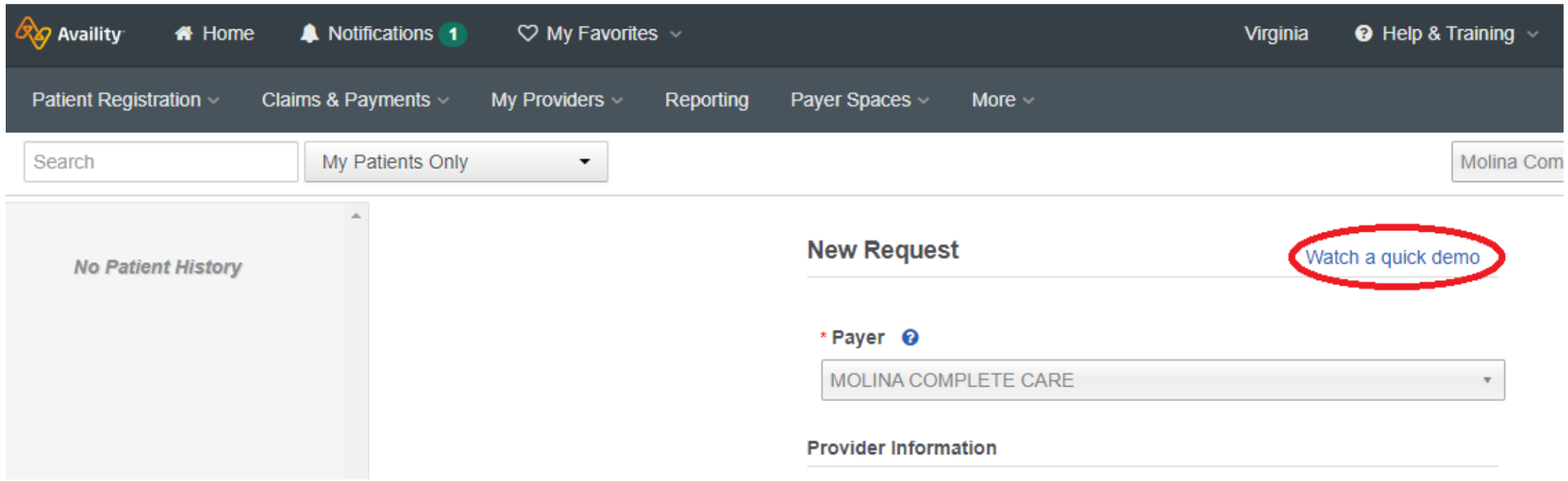
Multi-payer applications have on-screen demonstration links in the top righthand corner.

You will find embedded demonstration links for the below applications and more!

Eligibility and benefits

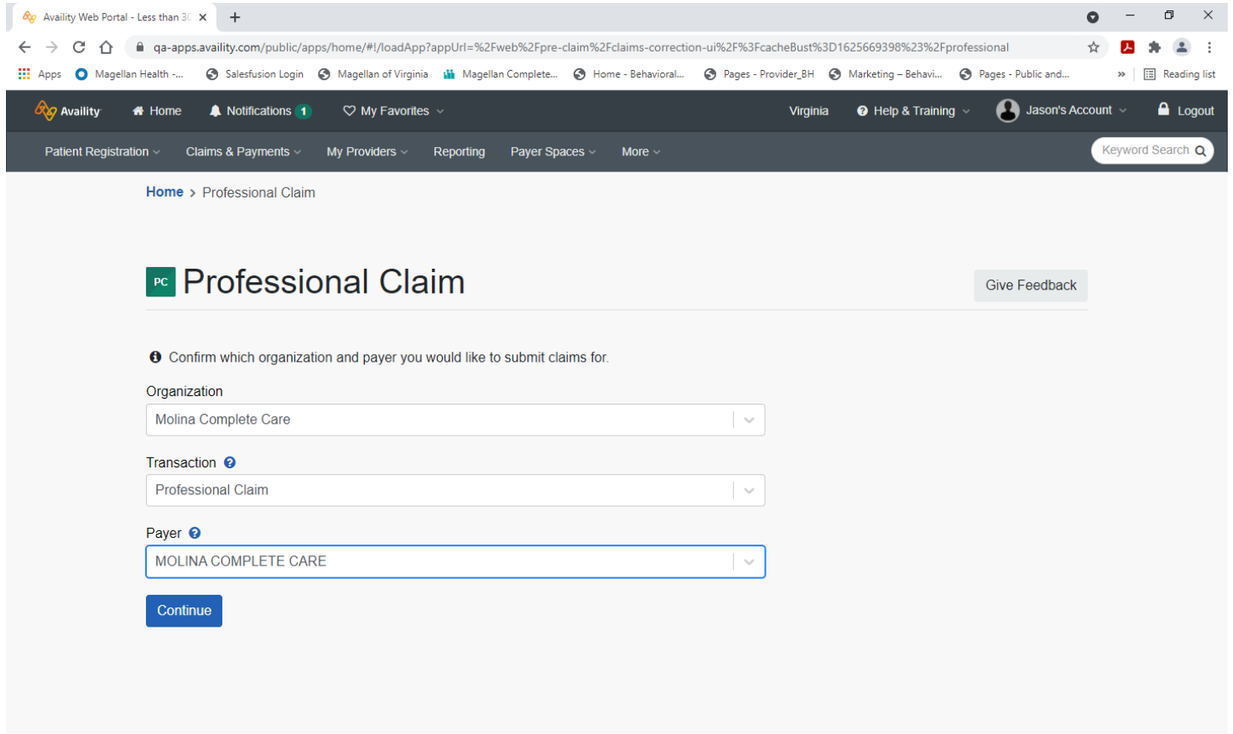
Claim submissions

Claim status



Availity Provider Portal (continued)

When you are submitting claims, be sure to select MOLINA COMPLETE CARE for BOTH Medical and Behavioral Health.



Availity Provider Portal (continued)

- Availity provider portal support is available two ways:
  - Availity Customer Service Line: 1-800-282-4548
  - Open a support ticket online at www.Availity.com and following these steps:

- MCC follows DMAS guidance regarding billing and reimbursement

Note: Providers must always bill the health plan for covered services provided to members. Balance billing is not permitted. Members cannot be charged for the difference of the amount the provider is reimbursed and the charge for the service.

MCC's Outside Vendors and Contact Information

Service	Vendor	Contact
Behavioral Health	Magellan Health	BH Provider Network: Phone: 1-800-424-4536 Fax: 1-888-656-1409 Email: VAProviderQuestions@magellanhealth.com BH Authorizations: Fax: 855-339-8179 Email: BHUMMCCofVA@magellanhealth.com
Dental	DentaQuest—routine, preventive, and limited restorative services	1-800-964-7811
Vision	VSP—routine vision care Services	1-800-877-7195
Lab services	LabCorp	1-888-522-2677
Transportation	Veyo (non-emergency)	1-877-790-9472
Dialysis	Fresenius/DaVita	CCC Plus: 1-800-424-4524 Medallion 4.0: 1-800-424-4518
Orthotics/Prosthetics	Hangar Orthotics and Prosthetics	CCC Plus: 1-800-424-4524 Medallion 4.0: 1-800-424-4518
Radiology	NIA Magellan Healthcare	CCC Plus: 1-800-424-4524 Medallion 4.0: 1-800-424-4518
Pharmacy	Magellan RX Management	1-800-327-8613

Molina Complete Care Behavioral Health Information

Molina Provider Portal – Behavioral Health

Providers contracted with Molina for behavioral health services can access www.MagellanProvider.com for updating practice information and roster maintenance.

Updating your practice data is critical to all transactions with Molina.

Practice data impacts:

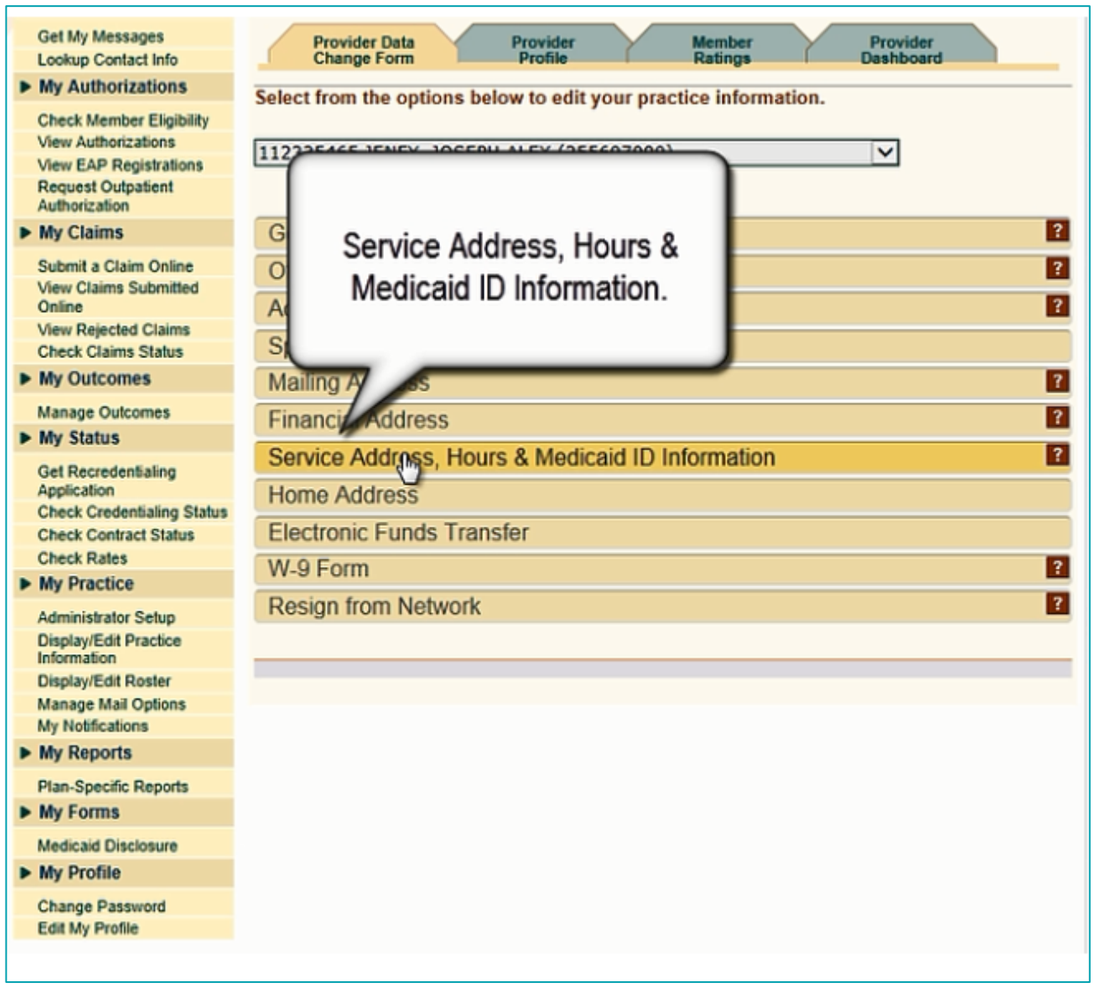
- Authorization notifications
- Recredentialing notifications
- Network/contractual-related communications
- Provider directories
- Claims payment

Molina Provider Portal – Behavioral Health (continued)

Updating your practice data: what you need to do

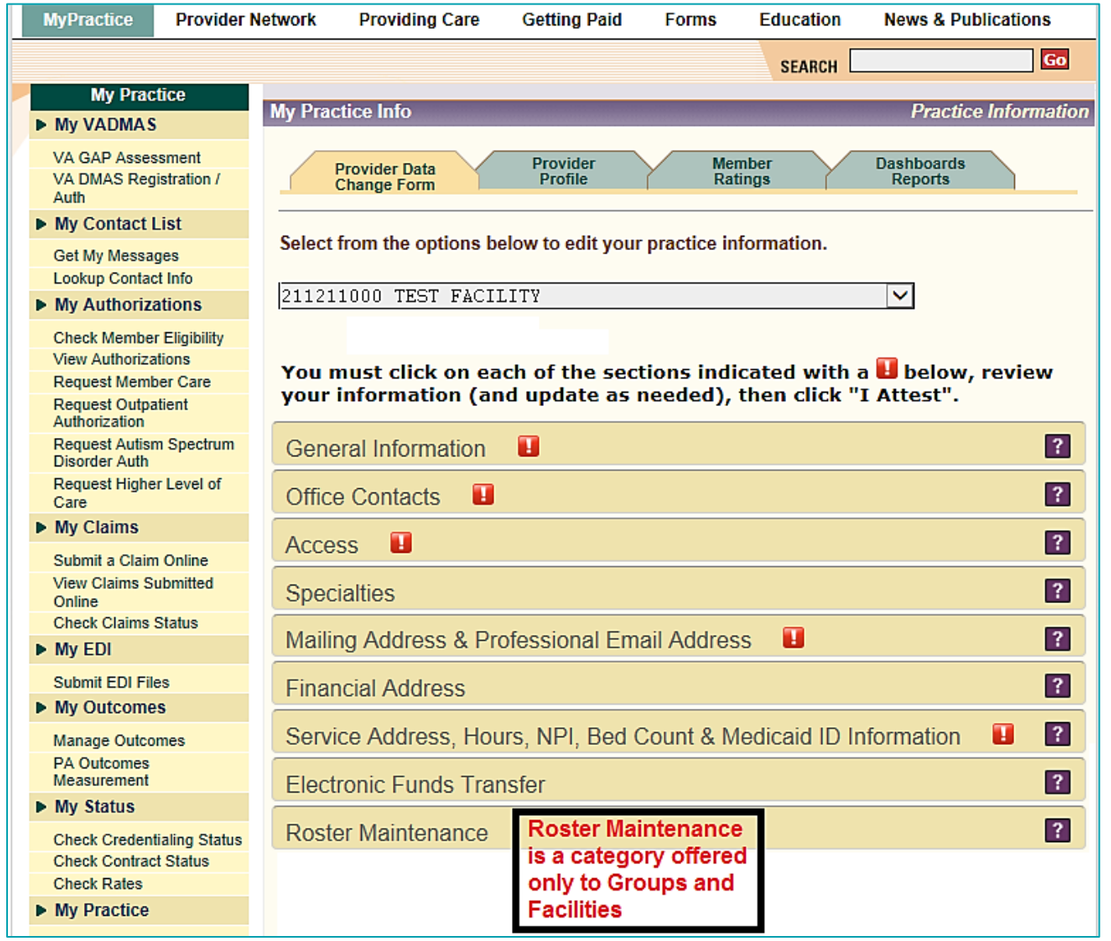
- Magellan's mandatory online Provider Data Change Form (PDCF) allows you to update your information in real time
  - Go to www.MagellanProvider.com
  - Sign into the secure network
  - Click Display/Edit Practice Information from the left-hand menu
- Training is available online under the Education menu on the provider website
- Magellan network staff members are also available to assist with provider training

Molina Provider Portal – Provider Data Change Form

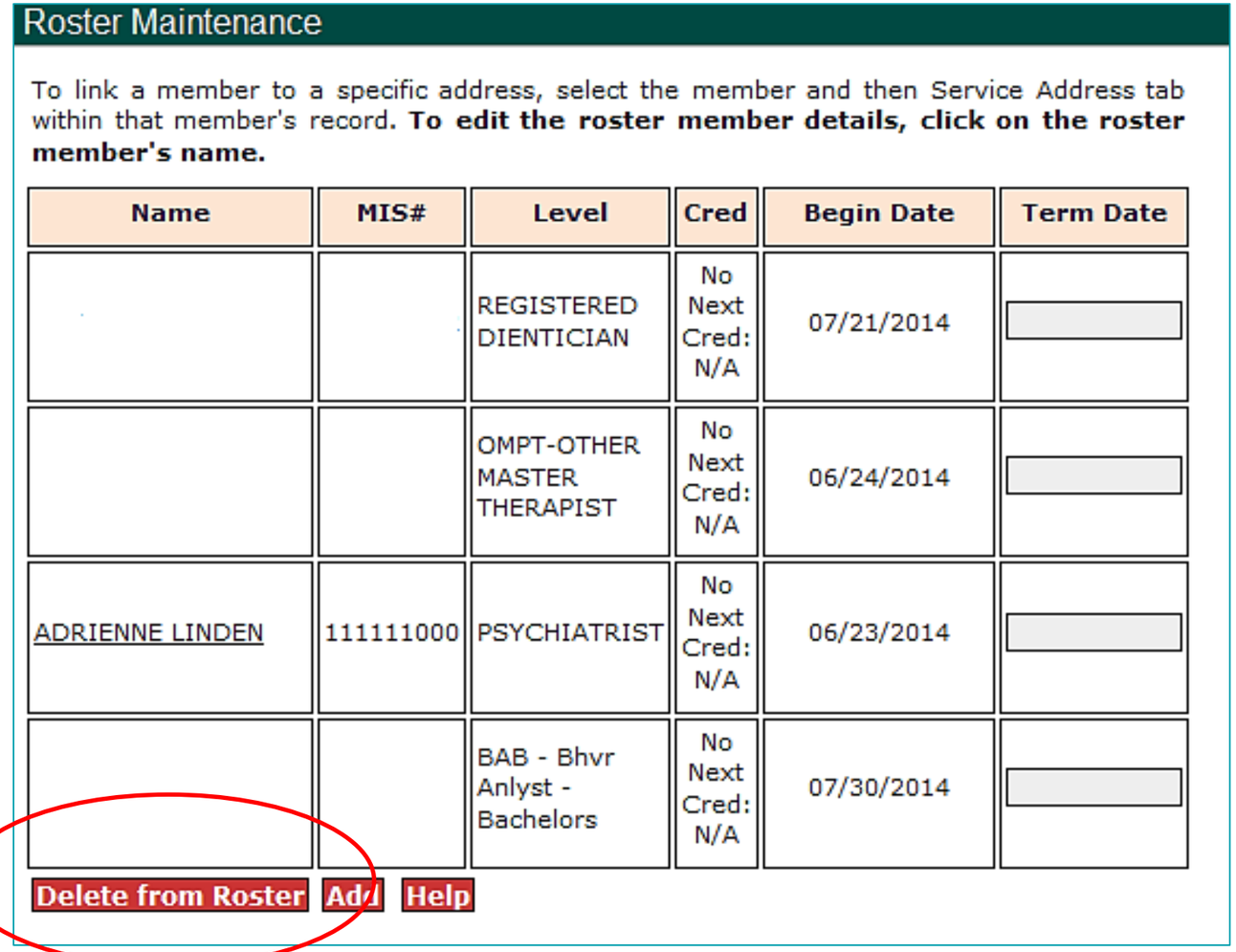


Molina Provider Portal – Roster Maintenance

- Roster Maintenance ensures that practitioners are only linked to the service address at which they are actually working
- Terminate providers who are no longer affiliated with the organization
- When adding new locations, be sure to add/link practitioners to the new site



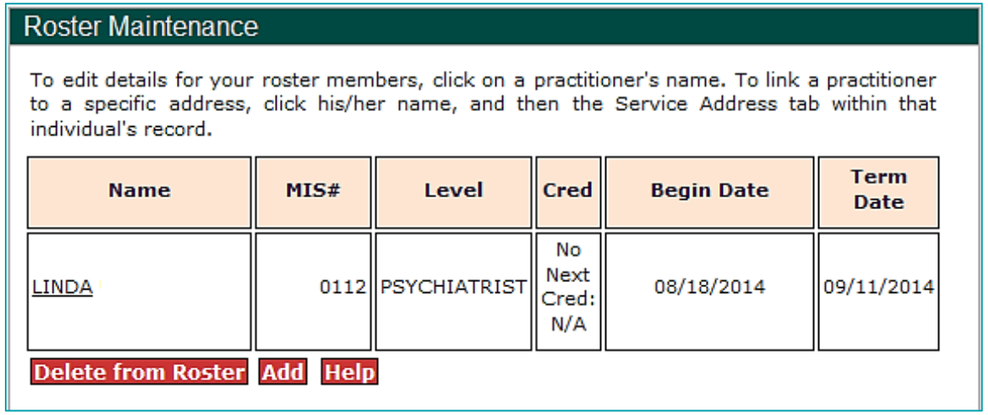
Molina Provider Portal – Roster Maintenance (continued)



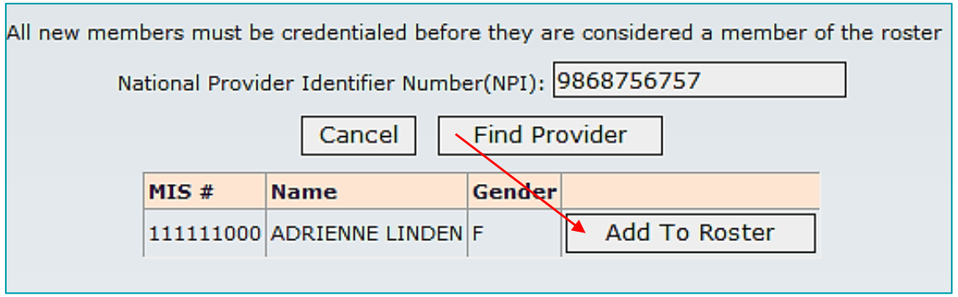
You can delete a provider from a roster by entering the future termination date and clicking Delete from Roster, or you can add a new provider to a roster

Molina Provider Portal – Roster Maintenance (continued)

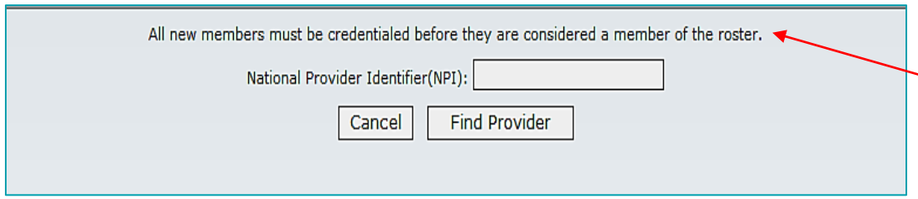
1. Click *Add*



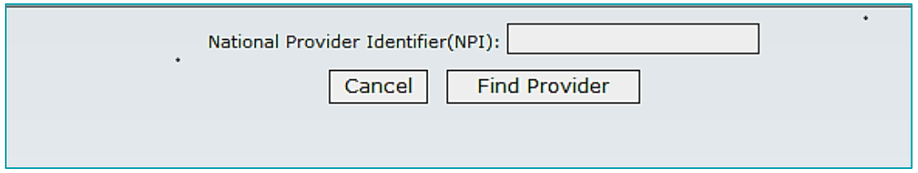
3. Click *Add To Roster*



2. Enter a VALID NPI and click Find Provider. Non-valid NPI numbers will not return results



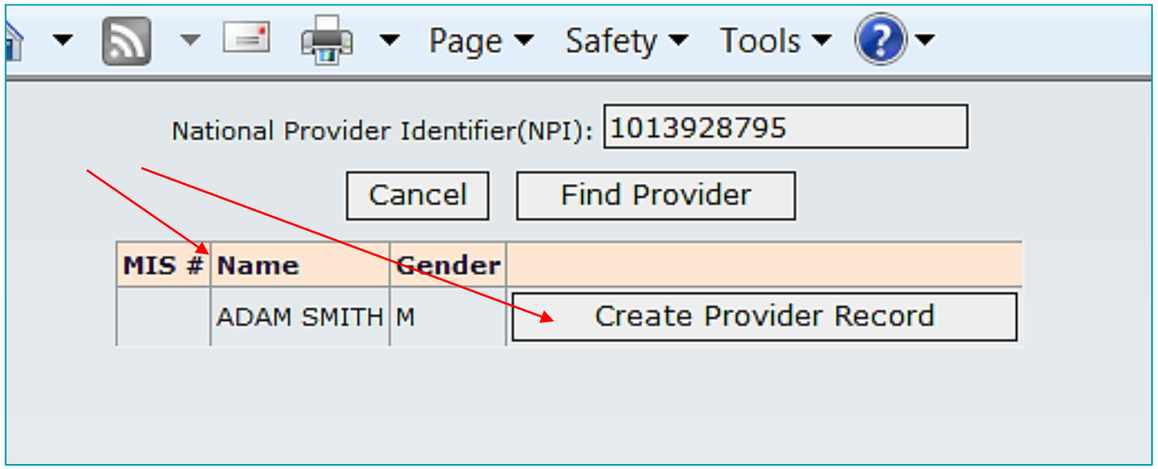
Credentialing message for *group* provider additions



***Facility* roster providers do not need to be credentialed before being added to the roster**

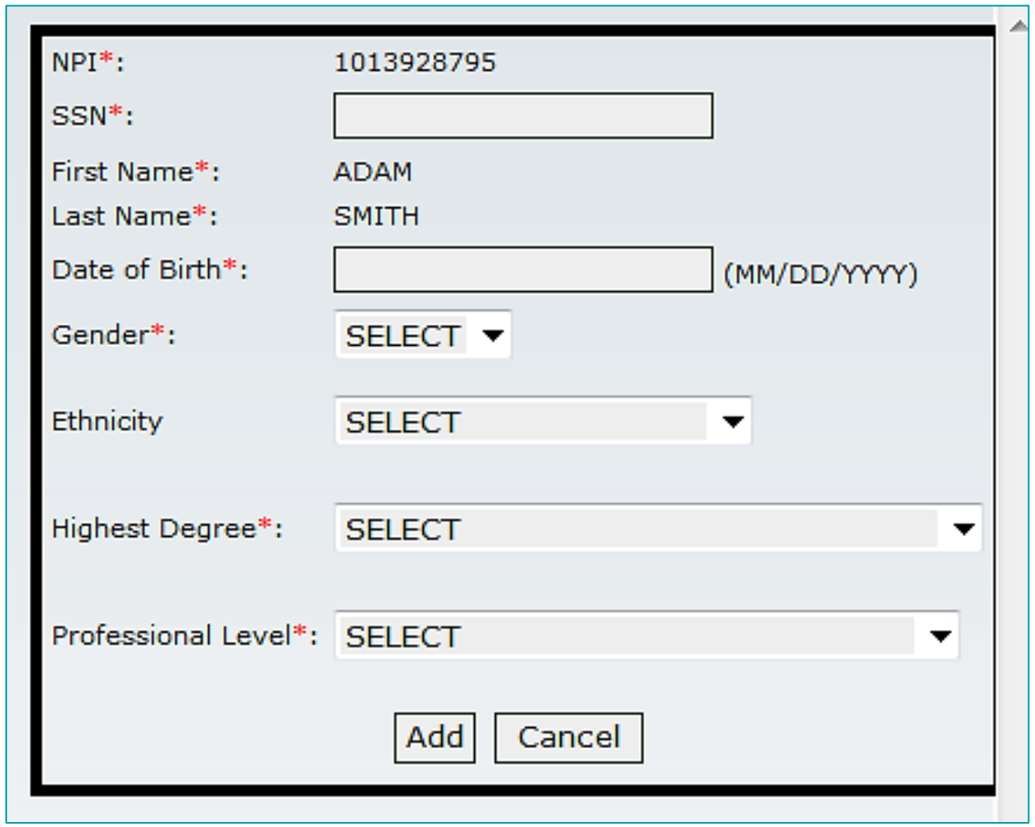
Molina Provider Portal – Roster Maintenance (continued)

4. Verify that the NPI you entered matches the name that is returned
5. If the name matches the NPI, click *Create Provider Record*

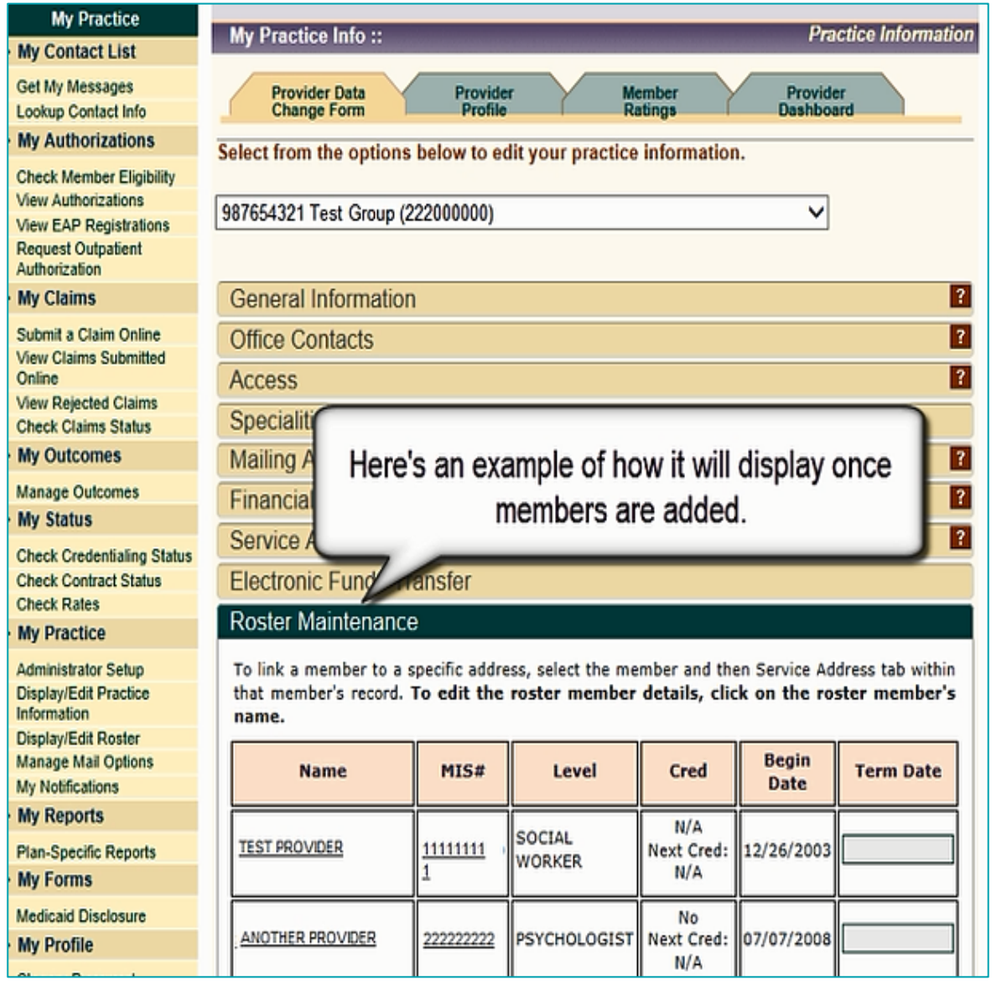


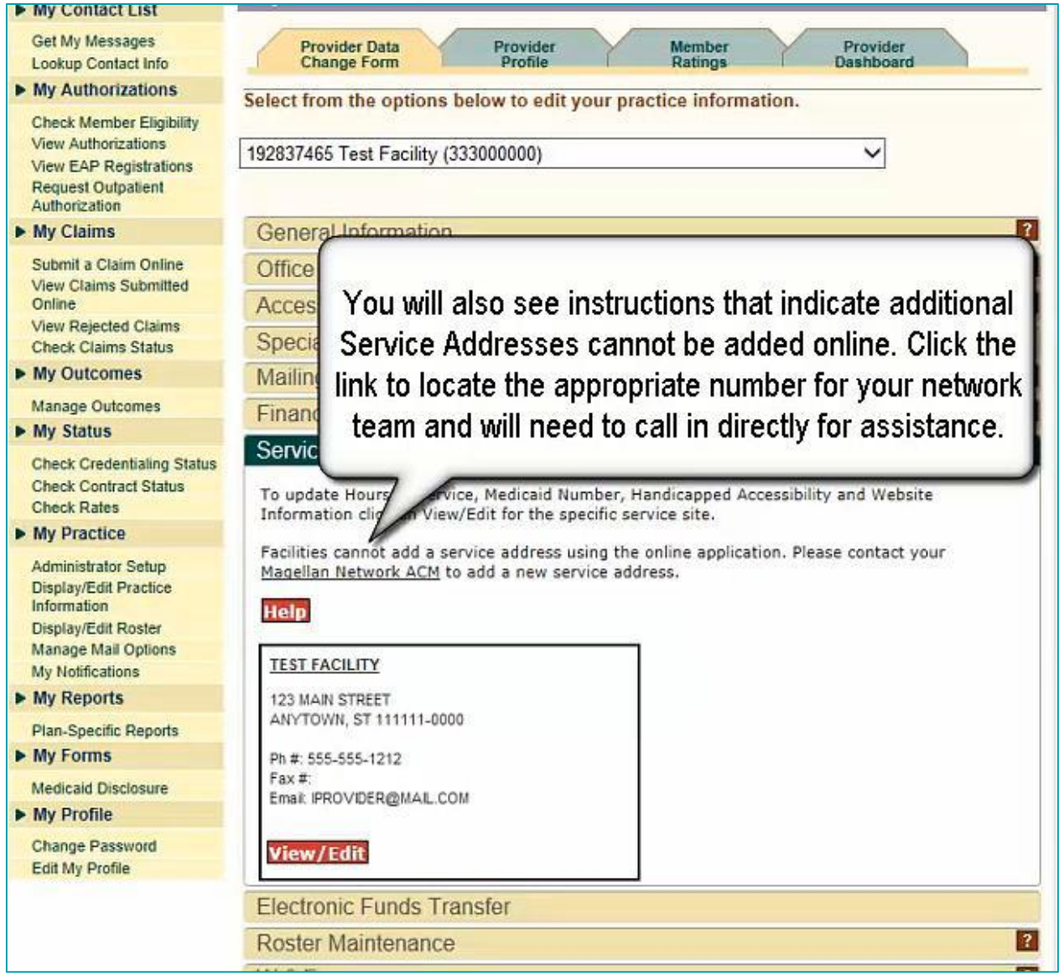
Molina Provider Portal – Roster Maintenance (continued)

6. This box will appear pre-populated with the provider's name and NPI. Simply enter SSN, DOB and the additional required fields and then click *Add*



Molina Provider Portal – Roster Maintenance (continued)

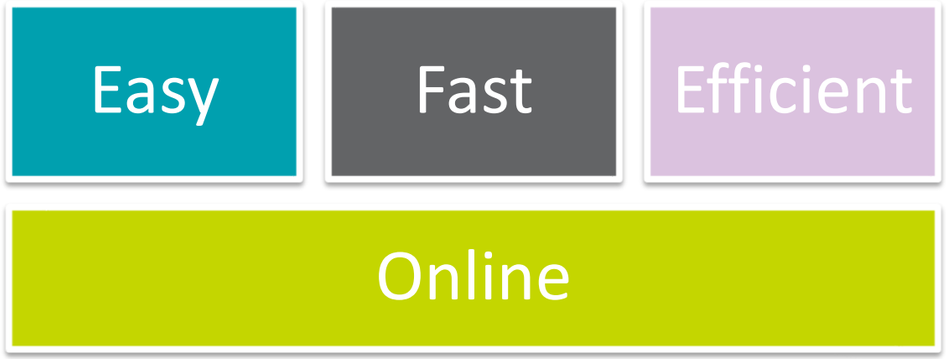




Authorization Information

Availity Online Authorization

Authorizations your way for Medical and Behavioral Health!



Authorization Requirements

Service authorizations are not required for:

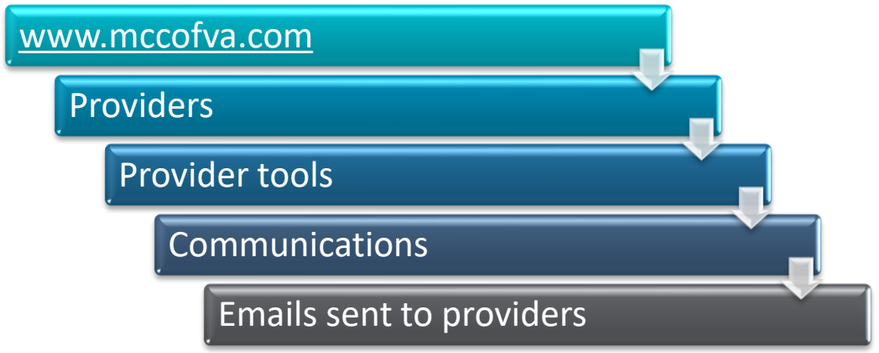
- early intervention services
- EPSDT
- emergency care
- family planning services, including long-acting reversible contraceptives (LARC)
- preventive services
- basic prenatal care
- services covered by Medicare, unless the Medicare benefit limit is exhausted

Services requiring authorizations

Inpatient Hospital – Elective and Non-Elective Procedures	Hospital or Ambulatory Care Center-based Outpatient Surgery	Inpatient Skilled Nursing Facilities and Long Stay Hospital	Rehabilitation Services: Inpatient, Cardiac and Pulmonary
Transplant Evaluation Services	Abortions	Specialty Drugs	IV Infusion or Injectable Medications
Outpatient Diagnostic Services; High-Tech Radiology; Chiropractic Services; and Acupuncture	Cardiac Testing; Genetic Testing; Experimental or Investigational	Behavioral Health: Inpatient, Mid-level Rehab; ARTS, and Skill Building Services	Transportation Non-urgent ambulance and Non-ambulance
Dental – refer to DentaQuest; Dental Varnish Vision – refer to VSP Hearing and Hearing Aids	Medical Devices; Durable Medical Equipment; Prosthetics/Orthotics and Replacements	Therapy: Physical, Occupational, Speech, Hyperbaric, Radiation, and Pain Management	Nutritional Supplements and Supplies; Infant Formula; Non-Emergency Referral to Non-contracted Provider
LTSS: Nursing Facility; Personal Care Skilled/Unskilled; Respite Skilled/Unskilled;	Home Health Care: Occupational, Physical or Speech; PDN; Home Health Aide RN/LCSW	Hospice; Transition Services; Specialized Care; Skilled Private duty nursing;	Adult Day Health Care; Assistive Technology; Environmental Modifications

Service Authorization Review Timeframes

- MCC follows review timeframe standards established by two entities:
  - The Department of Medical Assistance Services (DMAS)
  - The National Committee for Quality Assurance (NCQA)
- MCC released a provider notice with a listing of review timeframes for a full range of service types and levels of urgency
  - September 2019 E-blast: Utilization Management Reminders



Availity Online Authorizations

Are you ready to sign up?

- Let us know you would like to participate
  - Tell your network representative
  - Email us MCCVA-Provider@molinahealthcare.com
  - Sign up for the Availity provider portal if you are not yet registered
  - Go to www.Availity.com
  - Click “Register” in the upper righthand corner
  - Follow the prompts to register your account
  - Call Availity at 1-800-828-4548 for troubleshooting
- Watch a training
  - Contact your network representative to join a live training
  - You can also view a recorded presentation
    - Go to https://www.molinahealthcare.com/providers/va/medicaid/resources/provider-materials.aspx
    - Under “Provider Trainings” click:
      - Availity Provider Authorization Portal Training
- Provide feedback on improvement opportunities you find
  - E-mail us at MCCVA-Provider@molinahealthcare.com
  - You can also contact your network representative

Availity Online Authorizations (continued)

What are the advantages of online authorizations?

- Submit service authorization requests in real time
- Attach all clinical information via the portal for both initial requests and continued stays
- Quick reference numbers assigned automatically
- Fewer phone calls and faxes

What are the benefits of participation?

- Early adopters get all the advantages right now!
- Have your voice heard. Participating now allows you to share valuable feedback that we will use to refine and improve your future experience submitting authorization requests.

Appeals and Grievances

Complaints, Grievances and Appeals Process

MCC is required to have a system in place to respond to grievances, appeals and complaints received from members. We are required to provide information about the grievances and appeals processes to all network providers and subcontractors.

Provider Appeals Process

- **Provider appeals are requests made by providers (in-network and out-of-network) to review the adverse benefit determination in accordance with the statutes and regulations governing the Virginia Medicaid appeal process**
- **After a provider exhausts MCC's internal appeal process, Virginia Medicaid affords the provider the right to two (2) administrative levels of appeal (informal appeal and formal appeal)**

Submit your appeals to:

Molina Complete Care

Attn: Claims Specialist

3829 Gaskins Rd

Richmond, VA 23233-1437

Providers may also contact our MCC Customer Service:

- **CCC Plus: 1-800-424-4524**
- **Medallion 4.0: 1-800-424-4518**

- **A provider may file an appeal with MCC within 60 calendar days from the date of the adverse benefit determination notice/remittance advice**
- **A provider must file the appeal with MCC in writing**
- **The appeal must identify the issues, adjustments, or items the provider is appealing and include any supporting documentation which explains or satisfies the reason for the original denial and why it should be paid accordingly**
- **For appeals not resolved wholly in favor of the provider, MCC's written Notice of Internal Appeal Decision will include the description of appeal rights for DMAS appeal**

Provider Appeals and Timeframes

There are three types of provider appeals with different filing requirements:

Policy-related disputes

- Filing process – oral or written
- Timeliness – providers have 60 days from the date the provider becomes aware of the issue generating the complaint
- Forms can be found in the MCC Provider Handbook and on the Forms page of www.mccofva.com

Utilization management-related disputes

- Filing process – must be filed in writing
- Timeliness – providers have 60 calendar days from the original utilization management decision
- Forms can be found in the MCC Provider Handbook and on the Forms page of www.mccofva.com
- Submit written appeal requests to: MCC, Attn: Appeals Specialist, 3829 Gaskins Road, Richmond, VA 23233; or fax to 1-866-325-9157
- MCC will make a decision on routine appeals within 30 calendar days from the receipt of the appeal or within 72 hours for expedited review

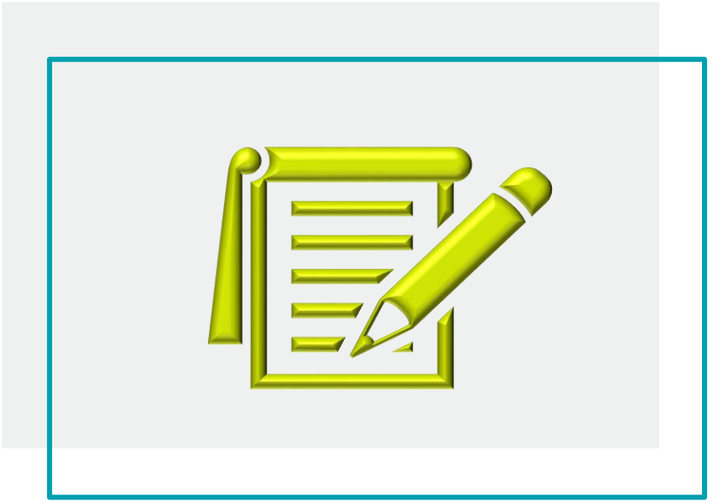
Claims-related disputes

- Filing process – must be filed in writing
- Timeliness – providers have 60 calendar days from the date of the adverse benefit determination notice/ remittance advice
- Complaints filed after that time will be denied for untimely filing
- Forms can be found in the MCC Provider Handbook and on the Forms page of www.mccofva.com
- Submit written appeal requests to: MCC, Attn: Appeals Specialist, 3829 Gaskins Road, Richmond, VA 23233; or fax to 1-866-325-9157

Required Documentation for Submitting a Dispute

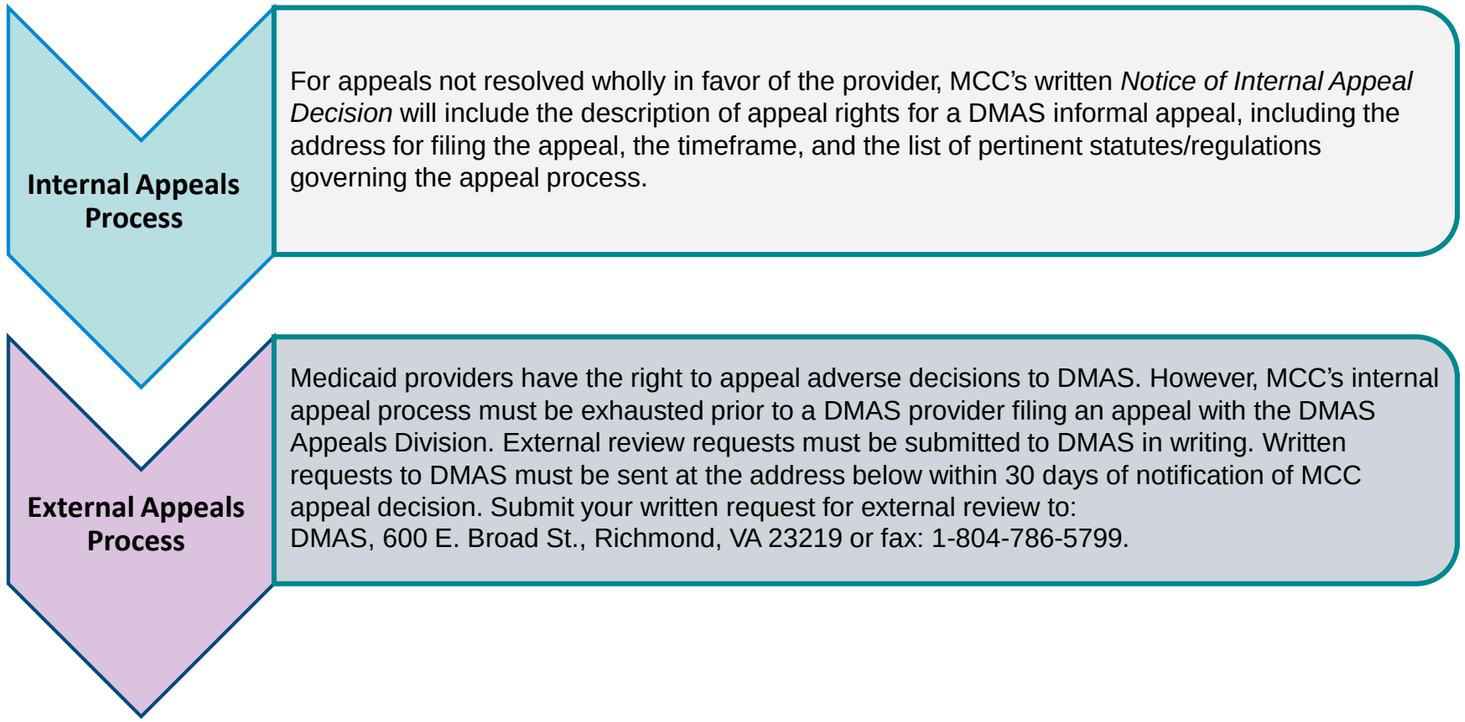
Insufficient documentation:

- The Provider Appeals form instructs the provider to submit any information necessary to reconsider MCC's initial claim or utilization decision
- If additional information is needed, our Provider Appeals department will notify the provider that we are denying the appeal due to lack of supporting documentation



Provider Appeal Resolution Process

All provider appeals will be thoroughly investigated using applicable statutory, regulatory and contractual provisions, collecting all pertinent facts from all parties and applying MCC written policies and procedures. At the conclusion of the review, the provider will receive a written decision with an explanation of the decision.



Provider Dispute Resolution Form

- The Provider Dispute Resolution form is available in the MCC Provider Handbook and via the mccofva.com website or call to initiate a provider appeal:
  - CCC Plus: 1-800-424-4524
  - Medallion 4.0: 1-800-424-4518
- Indicate one of the following reasons in the addressee line:
  - Retro review (no authorization)
  - Claims appeal
  - Appeals (clinical and administrative)
  - Customer comments (complaints)
- The submission should include:
  - Prior correspondence
  - Supporting documentation
  - Pertinent medical records (if applicable)
  - Detailed explanation providing the basis of the dispute
  - Identification of the issues, adjustments or items the provider is appealing

MCC
Attn: Appeals Specialist
3829 Gaskins Road
Richmond, VA 23233

What is a Member Appeal?

An appeal is an adverse action or benefit determination including any of the following:

- The denial or limited authorization of a requested service
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner, as defined by VA DMAS
- The failure of a managed care organization to act within the time frames provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities

To file an appeal:

CCC Plus members can call 1-800-424-4524

Medallion 4.0 members can call 1-800-424-4518

Monday through Friday from 8 a.m. to 8 p.m. local time.

Members can also write us at:

Molina Complete Care

Attn: Appeals Specialist

3829 Gaskins Rd

Richmond, VA 23233-1437

If needed, our agents can help complete an appeal request.

Interpreter services are available as needed.

Providers Appealing on behalf of Members

- MCC supports the right of our members and their designated representatives, which may include providers acting on the member's behalf, to request a review of adverse actions or benefit determinations, also known as an adverse determination
- MCC accepts appeal requests from our members and their designees for any covered service that has been denied, reduced, suspended or terminated
- A member's designee may be anyone who is authorized to file the appeals request on behalf of the member
- Members may file an appeal with MCC within 60 calendar days from the date on the adverse benefit determination notice
- MCC will make a decision on an appeal within 30 calendar days from the initial date of receipt of the appeal
- The written notification will include the decision, and if applicable, the reason for denial, including information on their second level appeal rights with DMAS

What is a Member Grievance?

- A grievance is an expression of dissatisfaction about any matter other than an “action.”
- A grievance is any complaint or dispute expressing dissatisfaction with any aspect of the contractor’s or provider’s operations, activities, or behavior.
- Possible subjects for grievances include, but are not limited to:
  - Quality of care or services provided
  - Aspects of interpersonal relationships such as rudeness of a PCP or employee of the contractor
  - Failure to respect the member’s rights

MCC will maintain a system that meets, at a minimum, the following standards:

- Timely acknowledgement of receipt of each member grievance
- Timely review of each member grievance
- Standard response, electronically, or in writing, to each member grievance within a reasonable time, but no later than 30 days after MCC receives the grievance
- Expedited response, orally or in writing, within 24 hours of when MCC receives the grievance, to each member whenever MCC extends the appeal timeframe or refuses to grant a request for an expedited appeal

State Fair Hearing Process

Members or their designated representatives have a right to appeal MCC's adverse determination on their appeal request through the State Fair Hearing process or DMAS's External Review Organization for FAMIS members.

If DMAS reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, MCC must authorize the disputed services no later than 72 hours from the date MCC receives the notice reversing the decision. MCC does not have the right to appeal DMAS's appeal decisions.

- The appeal for a State Fair Hearing (or external review for FAMIS members) must be filed within 120 days after receipt of MCC's appeal decision
- *Standard appeals* must be requested in writing by the member or their authorized representative
  - DMAS will resolve these within 90 days of the date of filing the appeal
- *Expedited appeals* may be filed by telephone or in writing
  - DMAS will resolve these within 3 business days

Compliance and Integrity

General Compliance Program

- Providers must ensure that their employees are knowledgeable about all applicable Medicaid requirements related to their job functions

- MCC must ensure that providers have implemented general compliance program training, including but not limited to:
  - General compliance and program integrity
  - Fraud, waste and abuse
  - Privacy and security
  - Cultural competence
  - Model of care

Confidentiality and HIPAA

As an MCC provider, your responsibility is to:

- Comply with applicable state and federal laws and regulations that pertain to member privacy and confidentiality of PHI
- Use only HIPAA-compliant authorization forms and consent for treatment forms that comply with applicable state and federal laws
- Use only secure email and secure messaging when requesting member PHI
- Establish office procedures regarding communication with members (e.g., telephone and cellphone use, written, fax and internet communication)
- Establish a process that allows members to access their records in a confidential manner
- Establish systems that safeguard member PHI at the provider location and anywhere PHI may be stored
- Maintain the confidentiality of a minor's consultation, examination and treatment for a sexually transmissible disease, in accordance with Virginia laws and regulations
- Participate in and comply with MCC quality review, site visit process and contract obligations

Provider Responsibilities regarding Fraud, Waste and Abuse

MCC has instituted extensive fraud, waste and abuse (FWA) programs.

It is the provider's responsibility to:

- Comply with all laws and MCC requirements regarding FWA
- Provide and bill only for medically necessary services that are delivered to members in accordance with MCC's policies, procedures and applicable regulations
- Ensure that all claims submissions are accurate
- Notify MCC immediately of any suspension, revocation, condition, limitation, qualification or other restriction on the provider's license
- Cooperate with MCC's investigations
- Refer to the MCC provider handbook for more information about FWA and reporting suspected FWA

Reporting Fraud, Waste and Abuse

Reports of FWA will be made to MCC via one of the following methods:

- Molina AlertLine: 1-866-606-3889
- Website: https://molinahealthcare.alertline.com

- Reports to the Molina AlertLine may be made 24 hours a day, 7 days a week.
- Callers may choose to remain anonymous
- All calls will be investigated and remain confidential

MCC of VA (HMO SNP)

A MEDICARE ADVANTAGE SPECIAL NEEDS PLAN THAT BEGAN JANUARY 1, 2020

MCC of VA (HMO SNP) Introduction

MCC of VA (HMO SNP) is a Medicare Advantage Special Needs Plan, also known as a Dual-Eligible Special Needs Plan (D-SNP). This plan is available to individuals who are enrolled in CCC Plus and are eligible for Medicare Parts A and B. Members get their Medicare and Part D benefits from their DSNP plan.

For more information, please visit www.mccofva.com/dsnp.

Coordination with Medicare and Medicaid

D-SNP members are eligible for full Medicaid CCC Plus standard benefits, as well as Medicare Parts A, B and D

Medicare covers:	Medicaid covers:	CCC Plus covers:
• Hospital care • Physician & ancillary services • Skilled nursing facility (SNF) care • Home healthcare • Hospice care • Prescription drugs • Durable medical equipment (DME)	• Medicare cost sharing • Hospital and SNF (when Medicare benefits are exhausted) • Nursing facility (custodial) • Home and community-based services (HCBS) waiver services • Community behavioral health and substance use disorder services • Medicare non-covered services, like OTC drugs, some DME and supplies, etc.	• Medicaid services • Medicare coinsurance and deductibles • Coordination with the members Medicare health plan • Dual Special Needs Plan (DSNP) contracts facilitate care coordination across the full delivery system • Option to choose the same health plan for Medicare and Medicaid

MCC of VA (HMO SNP) Customer Service

MCC of VA (HMO SNP) customer service:

1-800-424-4461

Call this number for support with all your provider needs.

For more information, please visit our MCC of VA (HMO SNP) website: www.mccofva.com/dsnp

MCC of VA (HMO SNP) Contact Information

MCC of VA (HMO SNP) Utilization Management (UM) – Authorizations

Phone	1-800-424-4495
Network fax	1-888-656-5098
Fax for PCP assessments	1-888-656-2391
Medical & behavioral email	MCCVA-Provider@molinahealthcare.com

MCC of VA (HMO SNP) Claims

Claims inquiry phone	1-800-424-4461
Paper claims address	P.O. Box 986 Elk Grove Village, IL 60009
Payer ID	MCC02

MCC of VA (HMO SNP) Contact Information (continued)

MCC of VA (HMO SNP) Provider Network Department

Phone	1-800-424-4495
Network email	MCCVA-Provider@molinahealthcare.com
Network fax	1-888-656-5098
MCC roster submissions	MCCVA-Providerroster@molinahealthcare.com
Behavioral health network phone	1-800-424-4536
Behavioral health network email	VAProviderQuestions@MagellanHealth.com
Behavioral health provider portal	www.MagellanProvider.com

MCC of VA (HMO SNP) Grievances and Appeals

Grievances	1-800-424-4495
Provider appeals	1-617-551-5053
Member appeals	1-800-424-4495
Appeals fax	1-855-838-7998
Appeals address	58 Charles St Cambridge, MA 02141

MCC of VA (HMO SNP) Contact Information (continued)

MCC of VA (HMO SNP) Provider Network Department

Phone	1-800-424-4495
UM after-hours phone	1-888-372-6421
Medical UM fax	1-888-656-2389
Behavioral UM fax	1-888-656-2621
Behavioral secure UM email	BHUMMCCofVA@magellanhealth.com
Medical Provider Portal	dsnp.mccofva.com/providers/provider-portal-sign-in/
Behavioral Provider Portal	www.MagellanProvider.com
UM mailing address	MCC DSNP UM 3289 Gaskins Rd Glen Allen, VA 23233

General Information

Verify Member Eligibility and Benefits

It is important that you verify eligibility and benefits for MCC members each time a member presents to your office or practice for care or prior to scheduling a care visit with a member.

The member ID card alone can not be solely relied upon as a guarantee of payment. Service authorizations are also contingent upon eligibility and benefits at the point of service.

Providers can access the following methods to verify eligibility:

Online: Visit the MCC provider portal at www.Availity.com

Phone: Call MCC customer service:

CCC Plus: 1-800-424-4524
Medallion 4.0: 1-800-424-4518

Provider Website

Our provider website is continually updated to provide easy access to information and greater convenience. Visit our website at: www.mccofva.com.

Available resources include:

Provider handbooks
Claims forms and submission tips
Compliance information
Pharmacy directory
Medication formulary
Services/medications requiring prior authorization
Provider network information
CMS Best Available Evidence policy
Clinical and administrative forms
Online provider education resources
Answers to frequently asked questions (FAQs)
Access to Interpretive and Translation Services

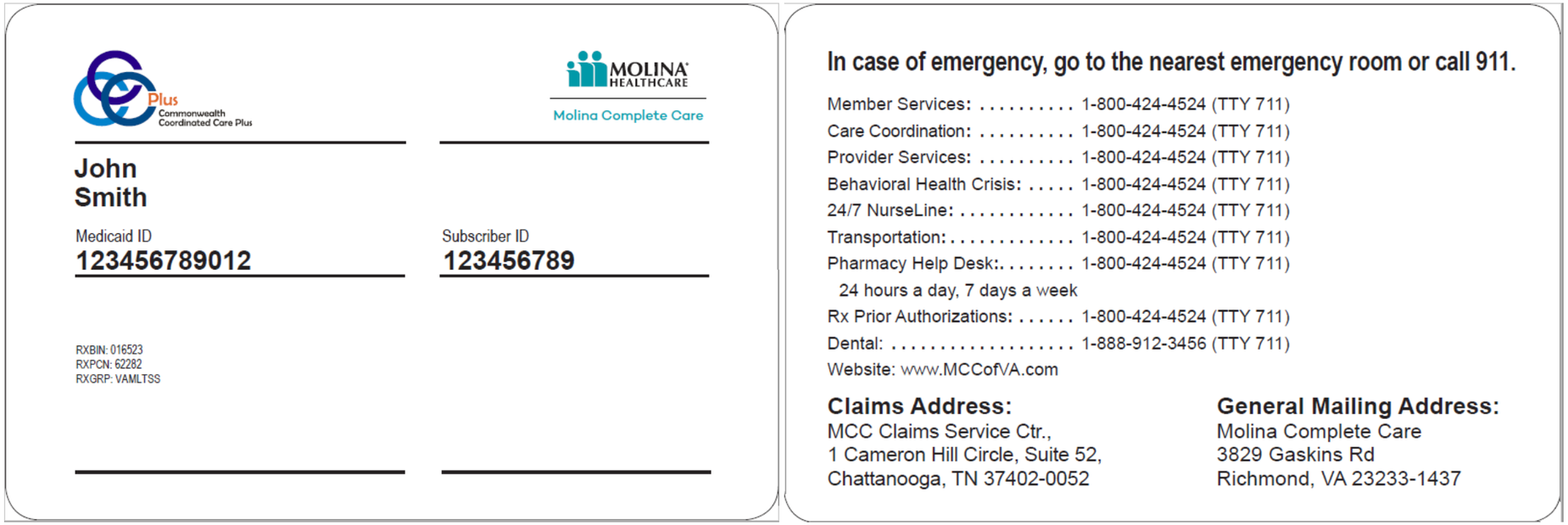
Provider Tools

Visit www.mccofva.com for our Provider Tools page.

In this section, you will find information and resources on:

- Important Updates
  - EFT Registration
  - Availity Sign On Instructions
- Provider training
  - Provider orientation
  - Claims education
- Utilization management
- Forms
  - Claims
  - Appeals
  - General
- Provider communications

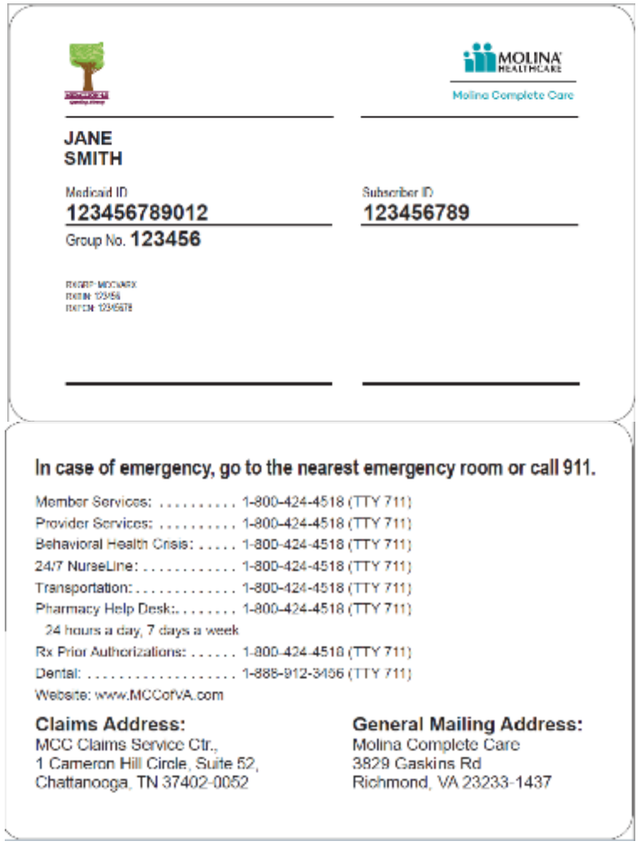
CCC Plus Member ID Card



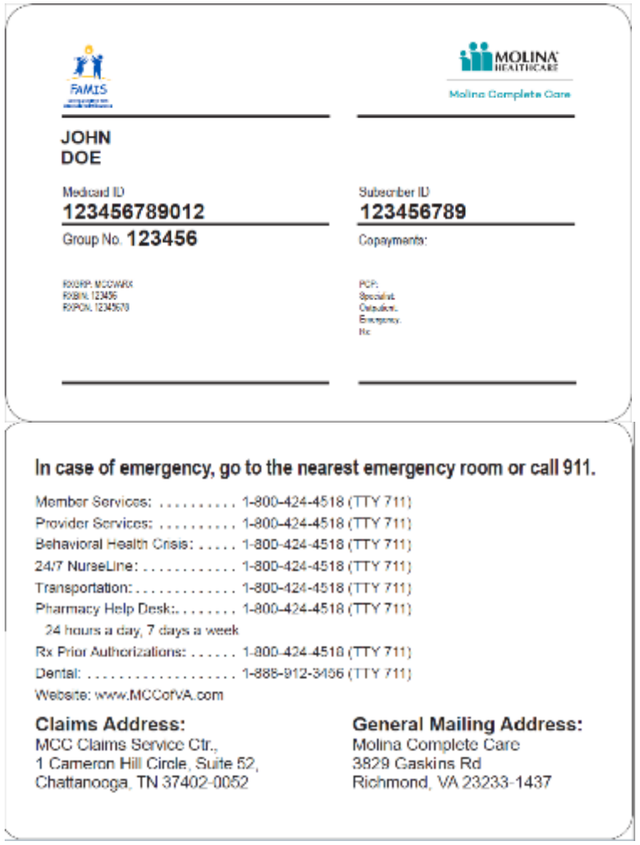
MOLINA HEALTHCARE

Medallion 4.0 and FAMIS Member ID Cards

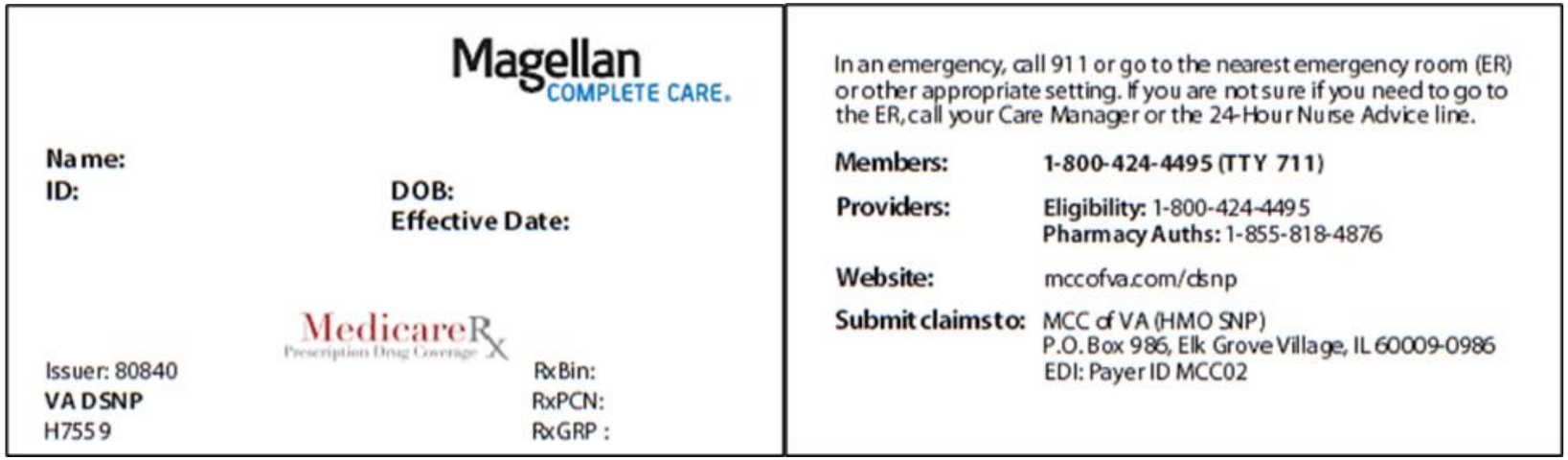
Medallion 4.0



FAMIS



MCC of VA HMO SNP Member ID Card



Q&A

Thank you for everything you do for our members.

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