Rural Health Clinics (RHC)

Molina Healthcare 2019

MOLINA HEALTHCARE

RHC Services

The Division of Medicaid limits reimbursement for RHCs to no more than four (4) encounters per beneficiary per day, provided that each encounter represents a different provider type, as the Division of Medicaid only reimburses for one (1) medically necessary encounter per beneficiary per day for each of the following provider types:

1. A physician, physician assistant, nurse practitioner, or nurse midwife,
2. A dentist,
3. An optometrist, or
4. A clinical psychologist or clinical social worker.

RHC Services

RHC visits cannot take place in the following locations:

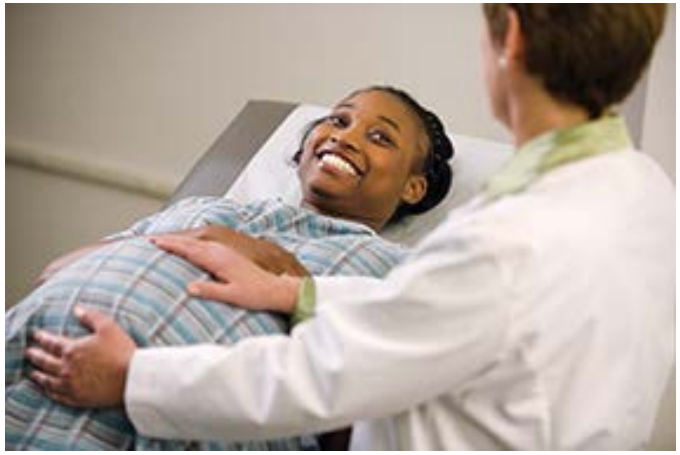
1. An inpatient or outpatient hospital,
2. A facility with specific requirements that exclude RHC visits.

RHC Enrollment

All out-of-network providers must obtain a PA prior to rendering services. All Non-Par Providers require authorization regardless of services or codes.

To join our network, please complete the Contract Request Form found on our website at **https://www.molinahealthcare.com/providers/ms/medicaid/forms/Pages/fuf.aspx** and follow the instructions given.

After completing, a representative from our Provider Contracting Department will reach out to you regarding the enrollment and credentialing process.



RHC Rates

- Reimbursed based on medical fee-schedule
- Division of Medicaid Fee Schedule
  - https://medicaid.ms.gov/providers/fee-schedules-and-rates/#

EPSDT Services

EPSDT stands for **Early Periodic Screening, Diagnosis and Treatment.** EPSDT is a program of checkups and health care services for children under the age of 21 to detect and treat health problems. EPSDT checkups are free for all children who is a Molina Healthcare member.

- **Early:** Identifying problems early, starting at birth.
- **Periodic:** Checking children's health at periodic, age-appropriate intervals.
- **Screening**: Doing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems.
- **Diagnosis:** Performing diagnostic tests to follow up when a risk is identified.
- **Treatment:** Treating the problems found.

Prior Authorizations Submissions

Prior Authorization is required for outpatient surgeries and identified procedures, non-emergent inpatient admissions, Home Health, some durable medical equipment and Out-of-Network Professional Services.

Molina requires notification of all emergent inpatient admissions within twenty-four (24) hours of admission or by the close of the next business day when emergent admissions occur on weekends or holidays.

- For emergency admissions, notification of the admission shall occur once the patient has been stabilized in the emergency department.
- Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate inpatient review and discharge planning.
- Emergent inpatient admission services performed without meeting notification and Medical Necessity requirements or failure to include all of the needed documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient admission.

Requests for services listed on the Molina Healthcare Prior Authorization Guide are evaluated by licensed nurses and clinicians that have the authority to approve services.

Prior Authorizations and Referrals

Prior Authorization is a request for prospective review. It is designed to:

- Assist in benefit determination
- Prevent unanticipated denials of coverage
- Create a collaborative approach to determining the appropriate level of care for Members receiving services
- Identify Case Management and Disease Management opportunities
- Improve coordination of care

Referrals are made when medically necessary services are beyond the scope of the PCP's practice. Most referrals to in-network specialists do not require an authorization from Molina. Information is to be exchanged between the PCP and Specialist to coordinate care of the patient.

Requests for services listed on the Molina Healthcare Prior Authorization Guide are evaluated by licensed nurses and clinicians that have the authority to approve services.

A list of services and procedures that require prior authorization is included in our Provider Manual and also posted on our website at **MolinaHealthcare.com**

Request Submissions

Web Portal: https://eportal.molinahealthcare.com/Provider/Login

Phone: (844) 826-4335. Please follow the prompts for prior authorization.

Note: *For telephonically submitted requests, it may be necessary to submit additional documentation before the authorization can be processed.*

Fax: Prior authorization requests may be faxed to the Healthcare Services Department using the Molina Healthcare Service Request Form which is available on our website at: **MolinaHealthcare.com.**

Prior Authorizations:
Phone: 1 (844) 826-4335
Inpatient Requests Fax: 1 (844) 207-1622
All Non-Inpatient Fax: 1 (844) 207-1620

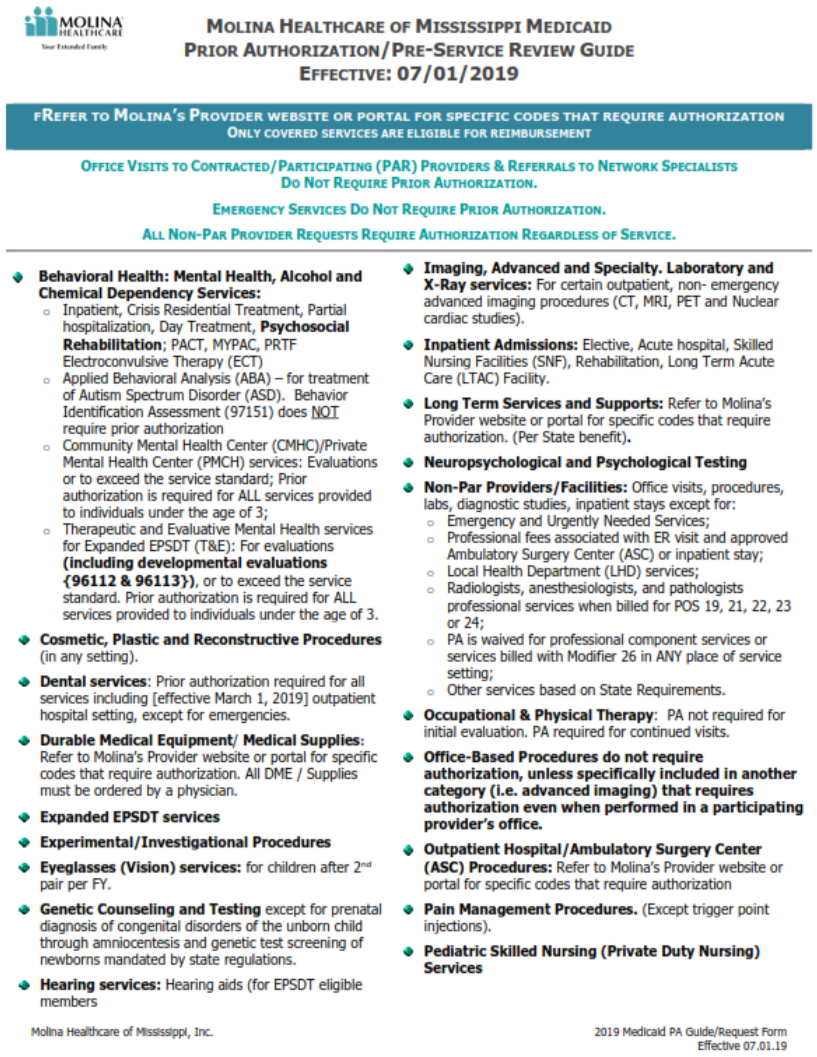
Behavioral Health Authorizations:
Phone: 1 (844) 826-4335
Inpatient Requests Fax: 1 (844) 207-1622
All Non-Inpatient Fax: 1 (844) 206-4006

Note: *Please indicate on the fax if the request is non-urgent or expedited/urgent. Please see the MHMS Provider Manual for definition of expedited/urgent.*

Mail:
188 East Capital Street
Suite 700
Jackson, MS 39201

Prior Authorization Review Guide

https://www.molinahealthcare.com/providers/ms/PDF/Medicaid/PA-Guide-Request-Form.pdf



MOLINA HEALTHCARE
Your Extended Family

MOLINA HEALTHCARE OF MISSISSIPPI MEDICAID
PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE
EFFECTIVE: 07/01/2019

REFER TO MOLINA'S PROVIDER WEBSITE OR PORTAL FOR SPECIFIC CODES THAT REQUIRE AUTHORIZATION
ONLY COVERED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT

OFFICE VISITS TO CONTRACTED/PARTICIPATING (PAR) PROVIDERS & REFERRALS TO NETWORK SPECIALISTS DO NOT REQUIRE PRIOR AUTHORIZATION.

EMERGENCY SERVICES DO NOT REQUIRE PRIOR AUTHORIZATION.

ALL NON-PAR PROVIDER REQUESTS REQUIRE AUTHORIZATION REGARDLESS OF SERVICE.

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Crisis Residential Treatment, Partial hospitalization, Day Treatment, **Psychosocial Rehabilitation**; PACT, MYPAC, PRTF Electroconvulsive Therapy (ECT)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD). Behavior Identification Assessment (97151) does NOT require prior authorization
  - Community Mental Health Center (CMHC)/Private Mental Health Center (PMCH) services: Evaluations or to exceed the service standard; Prior authorization is required for ALL services provided to individuals under the age of 3;
  - Therapeutic and Evaluative Mental Health services for Expanded EPSDT (T&E): For evaluations **(including developmental evaluations {96112 & 96113})**, or to exceed the service standard. Prior authorization is required for ALL services provided to individuals under the age of 3.
- **Cosmetic, Plastic and Reconstructive Procedures** (in any setting).
- **Dental services**: Prior authorization required for all services including [effective March 1, 2019] outpatient hospital setting, except for emergencies.
- **Durable Medical Equipment/ Medical Supplies:** Refer to Molina's Provider website or portal for specific codes that require authorization. All DME / Supplies must be ordered by a physician.
- **Expanded EPSDT services**
- **Experimental/Investigational Procedures**
- **Eyeglasses (Vision) services:** for children after 2nd pair per FY.
- **Genetic Counseling and Testing** except for prenatal diagnosis of congenital disorders of the unborn child through amniocentesis and genetic test screening of newborns mandated by state regulations.
- **Hearing services:** Hearing aids (for EPSDT eligible members
- **Imaging, Advanced and Specialty. Laboratory and X-Ray services:** For certain outpatient, non- emergency advanced imaging procedures (CT, MRI, PET and Nuclear cardiac studies).
- **Inpatient Admissions:** Elective, Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility.
- **Long Term Services and Supports:** Refer to Molina's Provider website or portal for specific codes that require authorization. (Per State benefit).
- **Neuropsychological and Psychological Testing**
- **Non-Par Providers/Facilities:** Office visits, procedures, labs, diagnostic studies, inpatient stays except for:
  - Emergency and Urgently Needed Services;
  - Professional fees associated with ER visit and approved Ambulatory Surgery Center (ASC) or inpatient stay;
  - Local Health Department (LHD) services;
  - Radiologists, anesthesiologists, and pathologists professional services when billed for POS 19, 21, 22, 23 or 24;
  - PA is waived for professional component services or services billed with Modifier 26 in ANY place of service setting;
  - Other services based on State Requirements.
- **Occupational & Physical Therapy**: PA not required for initial evaluation. PA required for continued visits.
- **Office-Based Procedures do not require authorization, unless specifically included in another category (i.e. advanced imaging) that requires authorization even when performed in a participating provider's office.**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:** Refer to Molina's Provider website or portal for specific codes that require authorization
- **Pain Management Procedures.** (Except trigger point injections).
- **Pediatric Skilled Nursing (Private Duty Nursing) Services**

Molina Healthcare of Mississippi, Inc.

2019 Medicaid PA Guide/Request Form
Effective 07.01.19

Pre-Service Review

Pre-service review defines the process, qualified personnel and timeframes for accepting, evaluating and replying to prior authorization requests.

- Pre-service review is required for all non-emergent inpatient admissions, outpatient surgery and identified procedures, Home Health, some durable medical equipment (DME) and Out-of-Network Professional Services. The pre-service review process assures the following:
  - Member eligibility;
  - Member covered benefits;
  - The service is not experimental or investigation in nature;
  - The service meets Medical Necessity criteria (according to accepted, nationally-recognized resources);
  - All covered services, e.g. test, procedure, are within the Provider's scope of practice;
  - The requested Provider can provide the service in a timely manner;
  - The receiving specialist(s) and/or hospital is/are provided the required medical information to evaluate a Member's condition;
  - The requested covered service is directed to the most appropriate contracted specialist, facility or vendor;
  - The service is provided at the appropriate level of care in the appropriate facility; e.g. outpatient versus inpatient or at appropriate level of inpatient care;
  - Continuity and coordination of care is maintained; and
  - The PCP is kept appraised of service requests and of the service provided to the Member by other Providers.

Post-Service Review

Post-Service Review applies when a Provider fails to seek authorization from Molina for services that require authorization.

- Failure to obtain authorization for an elective service that requires authorization may result in an administrative denial. Emergent services do not require authorization.
- Post service reviews related to retroactive eligibility are reviewed for medical necessity and will not be denied for failure to obtain prior authorization.
- Coverage of emergent services up to stabilization of the patient will be approved for payment. If the patient is subsequently admitted following emergent care services, authorization is required within one (1) business day or post stabilization stay will be denied
- Failure to obtain authorization when required will result in denial of payment for those services.
- The only potential exception for payment as a result of post-service review is if information is received indicating the provider did not know nor reasonably could have known that patient was a Molina member or in the case of an error by Molina, a medical necessity review will be performed.
- Decisions, in this circumstance, will be based on the following:
  - medical need; and
  - appropriateness of care guidelines defined by UM policies and criteria;
  - regulation and guidance; and
  - evidence based criteria sets.

Peer-to-Peer Review Process

- Peer-to-Peer review of an adverse determination may be requested if the Provider directing the Member's care wishes to provide additional information related to the authorization request.

- The requesting Provider has **five (5) business** days from the receipt of the denial notification to schedule the review.

- Requests can be made by contacting Molina at **(844) 826-4335**.

Concurrent Review

- Molina performs concurrent inpatient review in order to ensure patient safety, Medical Necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans.

- Molina will request updated original clinical records from inpatient facilities at regular intervals during a Member's inpatient admission.

This information is due from the inpatient facility within twenty-four (24) hours of the request.

Prior Authorization – Appeals

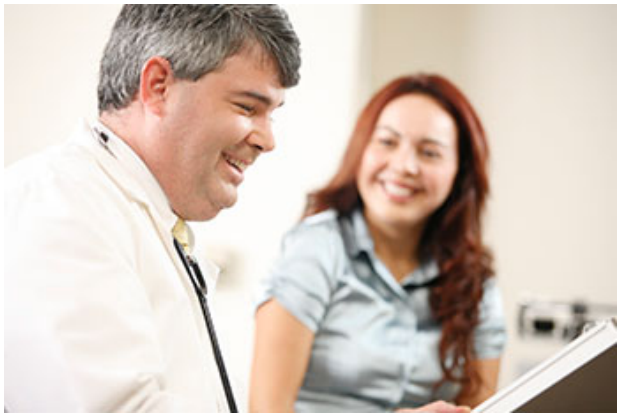
- Requests for authorization not meeting criteria must be reviewed by a designated Molina Medical Director or other appropriate clinical professional. Only a licensed physician (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist as appropriate) may determine to delay, modify or deny services to a Member for reasons of Medical Necessity.

- Board certified licensed Providers from appropriate specialty areas must be utilized to assist in making determinations of Medical Necessity, as appropriate. All utilization decisions must be made in a timely manner to accommodate the clinical urgency of the situation, in accordance with regulatory requirements and NCQA standards.

- Providers can contact Molina's Healthcare Services Utilization Management team at **(844) 826-4335** to obtain Molina's UM Criteria.

Prior Authorization – Appeals

- A Provider may file a formal Appeal orally or in writing, requesting Molina to review an Adverse Benefit Determination related to a Provider.
- Appeals must be filed within thirty (30) calendar days from the Adverse Benefit Determination or denial. A written acknowledgement letter must be sent within ten (10) calendar days of receipt of the Appeal. Appeals must be resolved as expeditiously as possible, and no later than thirty (30) calendar days from receipt.
- For decisions not resolved wholly in the Provider's favor, Providers have the right to request a State Administrative Hearing from the Division of Medicaid.



Effective Date Adjustment & Reimbursements

Effective dates and rates for RHCs are updated in our system when received from the Mississippi Division of Medicaid (DOM). Molina Healthcare reimburses the provider based on rates received from DOM.

- RHCs must file POS 72

Claim Submission Timeframes

Claims Submission	Time Frame
Initial Claim	180 Days from the DOS/180 Days from the Date of Discharge
Reconsideration/ Correction/Adjustment	90 Days from the date of denial/EOP
COB	180 Days from the Primary Payer's EOP

Claim Submission

Electronic Claims

(preferred method)

The Provider Portal

(**https://provider.molinahealthcare.com**) is available free of charge and allows for attachments to be included.

Clearinghouse

- Providers may use the Clearinghouse of their choosing. *(Note that fees may apply).*
- ClaimsNet is Molina Healthcare's chosen clearinghouse. When submitting EDI Claims (via a clearinghouse) to Molina Healthcare, providers must use the applicable **payer ID # 77010**

Paper Claims

Claims Mailing Address

Molina Healthcare of Mississippi, Inc.
PO Box 22618
Long Beach, CA 90801

EDI Claims Submission Information

- Molina Healthcare of Mississippi uses ClaimsNet as its gateway clearinghouse. ClaimsNet has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse.

- Molina accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for institutional. In order to ensure that all data being submitted to our gateway is received properly your submitter must utilize the latest version of the 837 standard. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

- ClaimsNet Payer ID# 77010

EDI Frequently Asked Questions

- **Can I submit COB claims electronically?**
  Yes, Molina and our connected Clearinghouses fully support electronic COB.

- **Do I need to submit a certain volume of claims to send EDI?**
  No, any number of claims via EDI saves both time and money.

- **Which Clearinghouses are currently available to submit EDI claims to Molina?**
  https://www.molinahealthcare.com/providers/common/medicaid/ediera/edi/Pages/chinfo.aspx

- **What claims transactions are currently accepted for EDI transmission?**
  837P (Professional claims), 837I (Institutional claims).

EDI Frequently Asked Questions

- **Where can I find more information on the HIPAA transactions?**
  https://www.molinahealthcare.com/providers/common/medicaid/ediera/edi/Pages/guidanceinfo.aspx

- **How do I exchange the 270/271 Eligibility Inquiry?**
  Molina does not directly exchange the Eligibility transactions. The transactions may be sent to Molina's contracted clearinghouse Change Healthcare to verify Eligibility.

- **How do I exchange the 276/277 Claim Status Inquiry/Response?**
  Molina does not directly exchange the Claim Status transactions. The transactions may be sent to Molina's contracted clearinghouse Change Healthcare to verify Claim Status.

EDI Claims Submission Issues

Providers can call the EDI customer service line at **(866) 409-2935**; and/or

Submit an email to **EDI.Claims@molinahealthcare.com**.

EDI Claims Contact Information

For questions about any of the following areas, please select the appropriate link:

- **Submitting Electronic: Claims, Referral Certification and Authorization**
  1-866-409-2935
  Email Directly: EDI.Claims@MolinaHealthcare.com

- **Submitting Electronic: Encounters**
  1-866-409-2935
  Email Directly: EDI.Encounters@MolinaHealthcare.com

- **Receiving 835/ERAs**
  1-866-409-2935
  Email Directly: EDI.eraeft@MolinaHealthcare.com

Electronic Funds Transfer & Remittance Advice (EFT & ERA)

Contracted Providers are required to register for EFT within 30 days of entering the Molina Network. Providers enrolled in EFT payments will automatically receive ERAs as well. Molina partners with Change Healthcare ProviderNet for EFT and ERA services. Additional information regarding EFTs and ERAs will be available under the "EDI, ERA/EFT" tab on the Molina website at **MolinaHealthcare.com/provider**.

Benefits of EFT/ERA:

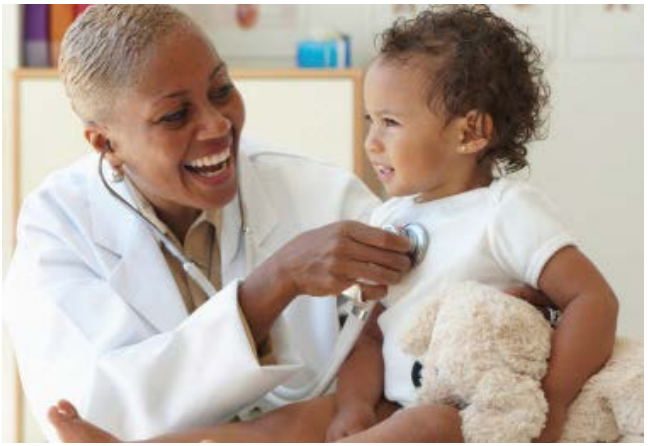
- Faster payment (as little as 3 days from the day the claim was electronically submitted)
- Search historical ERAs by claim number, member name, etc.
- View, print, download and save PDF ERAs for easy reference
- Providers can have files routed to their ftp and/or their associated clearinghouse

How to Enroll:

- To register for EFT/ERAs with Change Healthcare go to: **https://providernet.adminisource.com/Start.aspx**
- Step-by-step registration instructions are available on Molina's website (**www.molinahealthcare.com/provider**) under the "EDI, ERA/EFT" tab.

Claims Reconsideration

A Claims Reconsideration is written communication advising of the disagreement or dissatisfaction of claim determination.



Reconsideration must be accompanied by the following:

- Member demographic information,
- Supporting documentation outlining the specifics regarding the reason for the request.
- Refer to Molina Provider Manual for additional information

.

Claims Reconsideration

All reconsiderations must be received within ninety (90) days of the date on the Remittance Advice. Molina will respond to your request, in writing, within thirty (30) calendar days. Molina offers the following submission options:

Submit requests directly to Molina Healthcare of Mississippi via the Provider Portal at **provider.molinahealthcare.com**

Submit requests directly to Molina Healthcare of Mississippi by faxing to **1-844-808-2409**

Claims Reconsiderations, Disputes, and Appeals – Important Definitions

Adverse Benefit Determination
The denial or limited authorization of a requested service, including determinations on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized services; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the Division of Medicaid.

Provider appeal
Request for Molina to review an Adverse Benefit Determination related to a Provider; which may include, but is not limited to, for cause termination by Molina, or delay or non-payment for Covered Services.

Documentation needed for submission of Reconsiderations, Disputes, or Appeals

- All Claim Reconsiderations, Disputes or Appeals must be submitted on the Molina Claims Request for Reconsideration Form (CRRF) found on Molina's Provider website and the Provider Portal.
- The form must be filled out completely in order to be processed.
- Any documentation to support the reconsideration, dispute or appeal must be included, e.g. include Medical Records, copy of Explanation of Payment, copy of Authorization Form.
- If submitting voluminous Medical Records, please indicate where Molina can find pertinent information to support the medical necessity for the service.

Appeals Quick Reference

Molina Healthcare Member Resolution Team (MRT) and Provider Resolution Team (PRT) are working together to re-route any misdirected requests. However, participating providers sending disputes/appeal requests to the wrong department could delay response times.

Pre-Service Appeals

For providers seeking to appeal a denied Prior Authorization (PA) on behalf of a member only, fax Member Appeals at **(844) 808-2407**.

Post-Service Appeals

For providers seeking to appeal a denied claim only, fax Provider Claim Disputes/Appeals at **(844) 808-2409**.

If a provider rendered services without getting an approved PA first, providers must submit the claim and wait for a decision on the claim first before submitting a dispute/appeal to Molina.

How to File a Claim Reconsideration, Dispute or Appeal

Preferred Method – online via Molina's Provider Portal:
https://provider.MolinaHealthcare.com/provider/login

Fax: (844) 808-2409

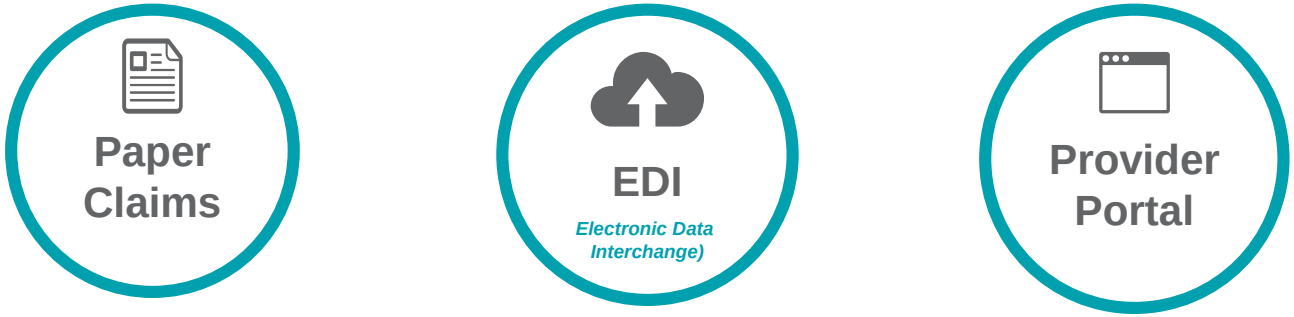
Mail:

Molina Healthcare of Mississippi, Inc.
Attention: Provider Grievance & Appeals
188 E. Capitol Street, Suite 700
Jackson, MS 39201

Corrected Claims

A corrected claim is a claim that has already been processed, whether paid or denied, and is resubmitted with additional charges, different procedure or diagnosis codes or any information that would change the way the claim originally processed. Claims returned requesting additional information or documentation should not be submitted as corrected claims. Corrected claims are treated as new claims.

Providers can submit corrected claims by the following:



Balance Billing

Providers **may not** balance bill Molina Members for any reason for covered services. Detailed information regarding the billing requirements for non-covered services are available in the MHMS Provider Manual.

Your Provider Agreement with MHMS requires that your office verify eligibility prior to rendering any service and obtain approval for those services that require prior authorization.

In the event of a denial of payment, providers shall look solely to MHMS for compensation for services rendered, with the exception of any applicable cost sharing/co-payments.

- The date of claim receipt is the date as indicated by its data stamp on the claim.
- The date of claim payment is the date of the check or other form of payment.

Rejected vs Denied Claim

Molina processes claims in an accurate and timely manner with minimal disturbances. Claim denials and rejections happen for a variety of reasons.

Rejected Claim
Claim does not meet basic claims processing requirements. A few examples of rejected claims include the use of an incorrect claim form, required fields are left blank or required information is printed outside the appropriate fields.

Denied Claim
The claim has been reviewed and was determined not to meet payment requirements. A few examples of reasons for denied claims include an invalid modifier, a missing: provider address, date of service or NPI and corrected claims indicator or original claim number.

Contact Information

Molina Healthcare of Mississippi, Inc.
188 E. Capitol Street, Suite 700
Jackson, MS 39201

Phone Numbers

Main Line Toll Free	(844) 826-4333
Member Eligibility Verification	(844) 809-8438
Member Services	(844) 809-8438
Provider Services	(844) 826-4335
Behavioral Health Authorizations	(844) 826-4335
Pharmacy Authorizations	(844) 826-4335
Radiology/Transplant/NICU Auths	(855) 714-2415

Fax Numbers

Main Fax	(844) 303-5188
Prior Auth – Inpatient	(844) 207-1622
Prior Auth – All Non-Inpatient	(844) 207-1620
Behavioral Health - Inpatient	(844) 207-1622
Behavioral Health /All Non-Inpatient	(844) 206-4006
Pharmacy Authorizations	(844) 312-6371
Radiology Authorizations	(877) 731-7218
Transplant Authorizations	(877) 813-1206
NICU Authorizations	(844) 207-1622

Vendors

Avesis
Toll Free: (833) 282-2419
Toll Free: (844) 826-4335
www.avesis.com

Southeastrans
Toll Free: (855) 391-2355
Toll Free: (844) 826-4335
www.southeastrans.com/members/mississippi

CVS Caremark
Toll Free: (844) 826-4335
PA submissions Fax: (844) 312-6371

March Vision
Toll Free: (844) 606-2724
Toll Free: (844) 826-4335
www.marchvisioncare.com

MOLINA HEALTHCARE