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PROVIDER ORIENTATION – HOSPICE

History

Molina Healthcare began 30 years ago in a small medical clinic in Long Beach, California. It was there that the Molina family children swept the floors, stocked shelves and filed medical records.

That year was 1980 and the healthcare environment was similar to that of today. Patients without a family physician would flock to emergency departments complaining of a sore throat or the flu. As an emergency room physician, Dr. C. David Molina knew that treating patients for simple everyday ailments in the emergency room cost more and caused longer waits for people with true emergencies.

As a result, Dr. Molina established a medical office to help those who were uninsured, non-English speaking or low income. This "medical home" enabled patients to access regular preventive care and a physician who was familiar with their health history who could provide the personalized care they couldn't get anywhere else.

Three decades later, Molina Healthcare is still led by a physician--but not any physician, the founder's son – Dr. J. Mario Molina. He and his siblings have gone from sweeping the floors of the first clinic to running the multi-state healthcare company.

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Recognition

- Molina Healthcare currently has eight NCQA accredited health plans. Therefore, Molina Healthcare is placed among the national leaders in quality Medicaid accreditations.
- For six years in a row, Molina Healthcare plans have been ranked among America's top Medicaid plans by U.S. News & World Report and NCQA.
- Fortune 500 Company
- Hispanic Business magazine ranked Molina Healthcare as the nation's largest Hispanic owned company in 2009.
- Time Magazine recognized Dr. J. Mario Molina, CEO of Molina Healthcare, as one of the 25 most influential Hispanics in America.

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LTC Program

Medicaid Recipients Required to Participate in LTC

- Recipients 65 years of age or older who need a nursing facility level of care, including hospice recipients residing in skilled nursing facilities (SNFs).

- Recipients 18 years of age or older who are eligible for Medicaid by reason of disability and who need nursing facility level of care.

- Recipients participating in the Aged and Disabled Adult, Assisted Living, Nursing Home Diversion, and Channeling Medicaid Waiver programs.

- Individuals participating in the Frail Elder Option.

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Dually Eligible Recipients

Medicaid Recipients Required to Participate in LTC

- 95% of individuals who enroll in the LTC program are dually eligible for both Medicare and Medicaid.
- Therefore, if these individuals need hospice, Medicare is the primary payor.

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Long Term Care Service Area

- Region 5 – Pasco, Pinellas
- Region 6- Hardee, Highlands, Hillsborough, Manatee, Polk
- Region 11 – Miami-Dade, Monroe

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Submitting Claims

Hospice may submit claims to Molina in the following ways:

- On paper, using a current version UB-04 form, to:

  Molina Healthcare
  PO Box 22812
  Long Beach, CA 90801

- Electronically, via a clearinghouse, using:

  Payer ID #51062

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Claims Payment

Molina will pay or deny claims from a Hospice, within the following timeframes:

- ❑ Electronic claims – within ten (10) days
- ❑ Paper Claims – within forty (40) days

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Pay to Information

The following fields on the UB-04 (837I equivalent) must match the information in our records in order for payment to be issued.

- ❑Field 1- Provider Name and Address must match W9 on file
- ❑Field 2 – Pay-to Name and Address (if applicable)
- ❑Field 5 – Tax ID must match W9 on file
- ❑Field 56 - NPI must match our files and NPI registry

Please notify Molina immediately, if any of these change.

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UB-04 on the Molina Web Portal

UB04 claims submission will soon be available on the Molina Web Portal.

Paper submitters can expect:

- Availability of the UB04 on the Web Portal by 3/31/2014
- Submit claims directly, without using a clearinghouse
- Payment in 10 days
- Track claims status (available now)

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Revenue Codes

Hospice should bill in accordance with Florida Medicaid guidelines.

Revenue Code	Description
651	Routine Home Care (per day)
652	Continuous Home Care (per hour)
655	Inpatient Respite Care
656	General Inpatient Care (non respite)
657	Physician Services
658	Hospice Room and Board - Nursing Facility

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Hospice Reimbursement

- Hospices will be paid at the Medicaid rate.
- For recipients residing in a nursing facility, the hospice will bill the LTC plan, then provide the SNF with the room and board payment.
- For a recipient who has Medicaid only, the LTC plan will be responsible for paying the hospice provider from the first day the individual is enrolled with the LTC plan.
- All plans will reimburse hospice providers at the established hospice rates posted on the AHCA portal at:

  http://ahca.myflorida.com/Medicaid/cost_reim/hospice_rates.shtml

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Patient Responsibility

Hospice must report patient responsibility on all claims. Payment to the Hospice will be the difference between the Hospice's Medicaid rate and the patient responsibility.

- Field 39 on paper UB04
- Loop 2300/CAS01 on EDI
- Use Value Code 31 and the monthly share of cost amount (leave blank if patient responsibility is $0. Do not report value code 31 and $0)

Molina will prorate the patient responsibility based on the number of days billed.

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Direct Deposit of Funds

Providers are encouraged to enroll in Electronic Funds Transfer (EFT) in order to receive payments quicker.

Molina Healthcare's EFT provider is ProviderNet.

To enroll, visit https://providernet.alegeus.com

Step-by step registration instructions are included in your training materials.

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Authorization Requests

To request authorization for additional services:

Contact the Member's Case Manager at: (866) 472-4585	or	Submit a Prior Authorization Request Form via fax at: (877) 902-6825

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Critical Incidents

Molina Healthcare has a critical and adverse incident reporting and management system for incidents that occur in a home and community-based long-term care service delivery setting.

Providers are required to report adverse incidents to Molina Healthcare within twenty-four (24) hours of the incident.

The incident shall be reported using the Critical Incident Reporting Form (available online)and submitted confidentially via fax.

Confidential fax number: (866) 472-6402

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Admission Notification

Providers must immediately notify a Molina Healthcare of Florida Community Plus case manager when a member requires hospitalization or has been admitted to the hospital, assisted living facility (ALF), or nursing home (NH). Notification must be given within 48 hours of knowledge of hospitalization.

The case manager will proactively assist the member with discharge planning needs prior to returning to the community by collaborating with family/caregiver(s), inpatient discharge planner and the facility. Inpatient hospitalizations are covered by Medicare fee-for-service program or the member's Medicare Advantage plan.

For additional information regarding hospital admissions and coverage, please contact Case Management at (866) 472-4585.

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Verifying Eligibility

Molina Healthcare of Florida offers various tools for verifying member eligibility. Providers may use our online self-service Web Portal, integrated voice response system (IVR), or speak with a Customer Service Representative.

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

Medicaid Customer Service: (866) 472-4585

Medicaid IVR Automated System: (866) 472-4585

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Provider Handbook

Our provider handbook is issued to providers after successful credentialing is completed. Providers can also request a hard copy of the handbook at no charge. From time to time, the provider handbook and bulletins will be updated and revised as our policies, or state and federal regulatory requirements change.

If a section is updated or changes are made to the content, the materials will be provided to you to replace the relevant section.

Providers may also call Provider Services and speak with a representative who will address any questions or concerns.

On the web: www.molinahealthcare.com

Provider Services Toll-Free Line: (866) 472-4585

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Provider Disputes

Any disagreement regarding the processing, payment or non-payment of a claim is considered a Provider Dispute. To file a Provider Dispute, providers may contact Customer Service at (866) 472-4585, or send the request for review in writing, along with any supporting documentation to the address below:

Molina Healthcare of Florida Community Plus
Attn: Provider Disputes
P.O. BOX 52740
Miami, FL 33152-7450
Fax: 877-553-6504

Provider Disputes must be received within one (1) year of the date of payment or denial of the claim. All provider disputes will be reviewed confidentially, and the outcome will be communicated in writing within sixty (60) days or receipt of the Provider Dispute.

If the Provider Dispute results in an unfavorable decision, and the provider has additional documentation supporting their position, the provider may resubmit the Provider Dispute for secondary review. In the alternative, providers may also request a review of their original appeal by the State's independent dispute resolution organization, listed below:

Maximus Federal Services State Appeals Process
50 Square Drive Suite 120
Victor, NY 14564
Tel. (866) 763-6395
Fax (585) 425-5296

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Credentialing

The Molina Healthcare Credentialing Department is responsible for performing, tracking or monitoring all aspects of the credentialing and re-credentialing process under the purview of the Quality Management Department for providers joining or participating in the Molina Healthcare network. The credentialing process is designed to meet the State of Florida Requirements and NCQA Standards.

Providers have the right to review their credentials file at any time. The provider must notify the Molina Healthcare Credentialing Department in writing and request an appointed time to review their file and allow up to seven calendar days to coordinate schedules.

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Verification and Approval

The Credentialing Department will verify the following provider information that includes but is not limited to:

- Current, unrestricted license
- Criminal history
- All professional and/or general liability claims history
- References (if applicable)
- Appropriate 24 hour coverage
- Identify any disciplinary actions and/or sanctions

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Background Checks

Any provider meeting the definition of a "direct service provider" must complete a Level II criminal history background screening to determine whether the provider, or any employees or volunteers of the provider have disqualifying offenses as provided for in s. 430.0402 F.S. and s. 435.04, F.S. Direct service providers are persons eighteen (18) years of age or older who, pursuant to a program to provide services to the elderly or disabled, has direct, face-to-face contact with a client while providing services to the client and has access to the client's living areas, funds, personal property, or personal identification information as defined I s. 817.568, F.S The term includes coordinators, managers, and supervisors of residential facilities and volunteers (see s. 430.0402(1)(b), F.S.)

Any provider, or any employees or volunteers of the provider who has a disqualifying offense is prohibited from contracting with Molina Healthcare of Florida.

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Provider Responsibilities

- Provide all services in an ethical, legal, culturally competent manner, free of discrimination against members based on age, race, creed, color, religion, gender, national origin, sexual orientation, marital, physical, mental, or socio-economic status
- Participate in and cooperate with Quality Improvement, Utilization Review, and other similar programs established by Molina Healthcare of Florida
- Participate in and cooperate with Molina Healthcare of Florida's grievance procedures
- Never balance bill Molina Healthcare of Florida members
- Comply with all federal and state laws regarding confidentiality of member records
- Participate in and cooperate with Molina Healthcare of Florida's Quality Management program to ensure the delivery of quality care in the most cost effective manner
- Have in place, and follow, written policies and procedures for processing requests for initial and continuing authorization of services
- Immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline toll-free telephone number, (800) 96ABUSE
- Maintain communication with appropriate agencies, such as local police, poison control, and social service agencies to ensure members receive quality care
- Contact a Molina Healthcare case manager if a member exhibits a significant change, is admitted to a hospital or hospice program.

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Provider Notifications

Providers will immediately notify Molina Healthcare of Florida, if any of the following events occur:

- Provider's business license to practice in any state is suspended, surrendered, revoked, terminated, or subject to terms of probation or other restrictions.
- Provider has any malpractice claim asserted against it by a Molina Healthcare of Florida Community Plus member, or any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of provider pursuant to a judgment rendered upon such a claim
- Provider is the subject of any criminal investigation or proceeding
- Provider is convicted for crimes involving moral turpitude or felonies
- Provider is named in any civil claim that may jeopardize Provider's financial soundness
- **There is a change in provider's business address, telephone number, ownership, or Tax Identification Number**
- Provider's professional or general liability insurance is reduced or canceled
- Provider becomes incapacitated such that the incapacity may interfere with member care for 24 hours
- Any material change or addition to the information submitted as part of provider's application for participation with Molina Healthcare of Florida Community Plus
- Any other act, event or occurrence which materially affects provider's ability to carry out its duties under the Provider Services Agreement

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Timely Filing

F.S. 641.3155 requires that providers submit all claims within six (6) months of the date of service. Network providers must make every effort to submit claims for payment in a timely manner, and within the statutory requirement.

If Molina Healthcare of Florida Community Plus is not the primary payer under coordination of benefits (COB), providers must submit claims for payment to Molina Healthcare of Florida Community Plus within ninety (90) days after the final determination by the primary payer.

Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted to Molina Healthcare of Florida Community Plus within these timelines will not be eligible for payment, and provider thereby waives any right to payment.

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Web Portal Tools

Member Eligibility	• Verify effective dates • Verify patient demographics
Claims	• Check claim status • Submit claims (professional only)
Authorizations	• Check status of an authorization • Request authorization

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Questions

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