# Medicaid Provider Orientation

## Provider Services | Molina Healthcare

last updated 2/1/2024

# Provider Services

## Satisfaction

- Provider representatives, advocates and engagement teams
- Annual assessment of provider satisfaction

## Communication

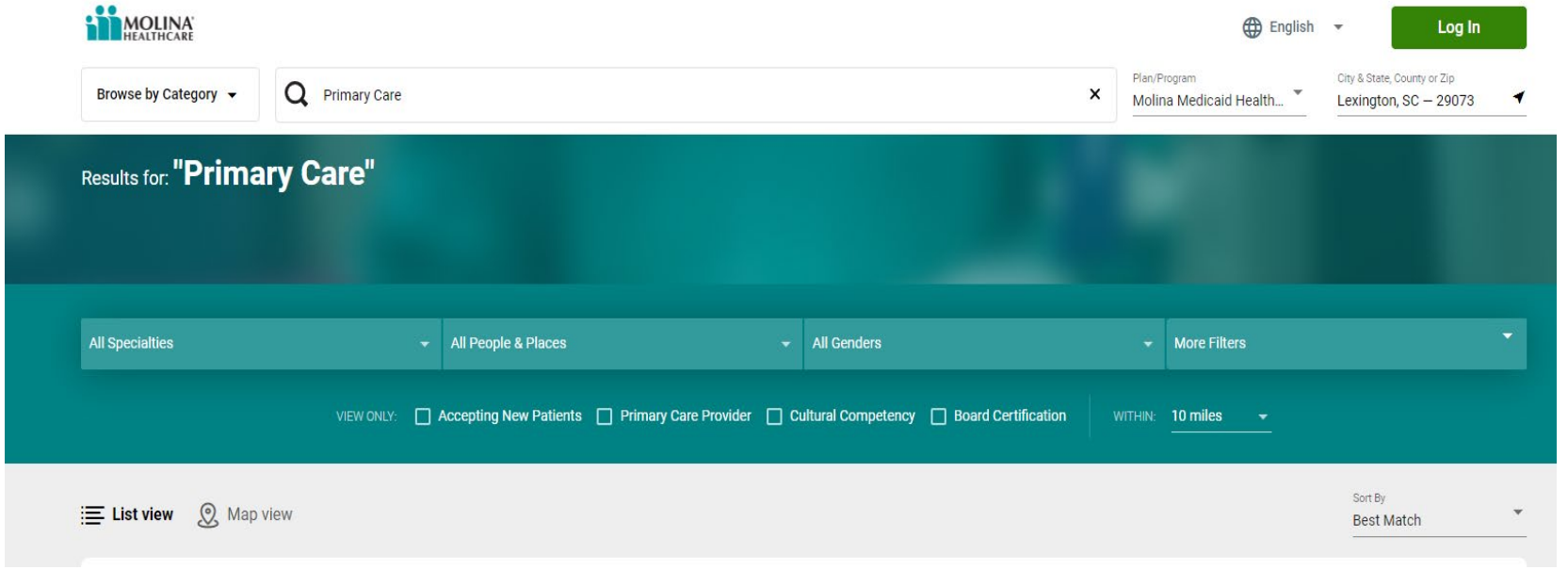
- *Provider Bulletin* and *Partners in Care* newsletters
- Online Provider Manuals
- Online trainings and Molina Web Portal
- Interactive Voice Response (IVR) Provider Service Line

## Technology

- 24-hour Web Portal
- Electronic Funds Transfer and Electronic Remittance Advice

# Provider Online Resources

- Provider Manuals
- Provider Online Directories
- Web Portal
- Preventive & Clinical Care Guidelines
- Prior Authorization Information
- Advanced Directives
- Pharmacy Information
- HIPAA
- Fraud, Waste and Abuse Information
- Frequently Used Forms
- Communications & Newsletters
- Member Rights & Responsibilities



# Provider Manuals

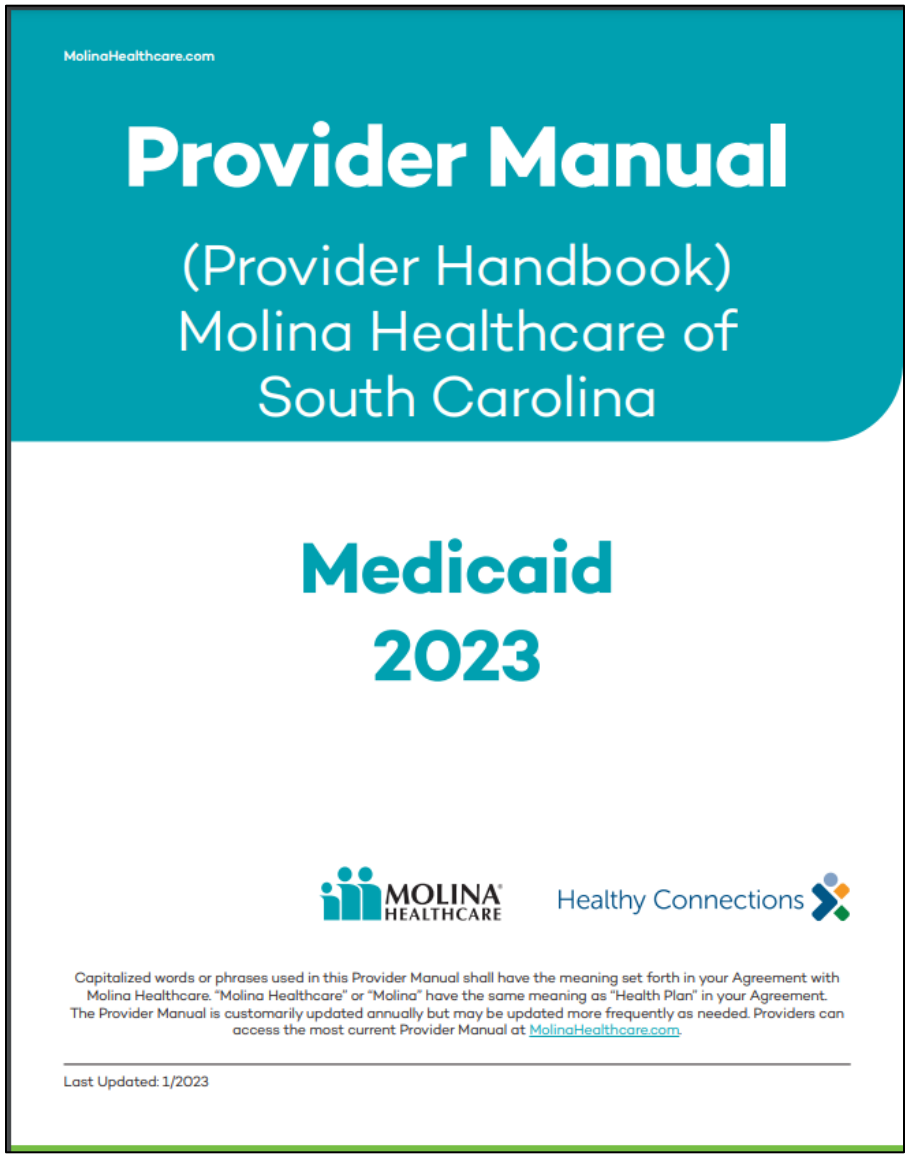
Molina Healthcare of South Carolina's Provider Manual is written specifically to address the requirements of delivering health care services to our members, including your responsibilities as a participating provider.

Medicaid

MMP (Dual)

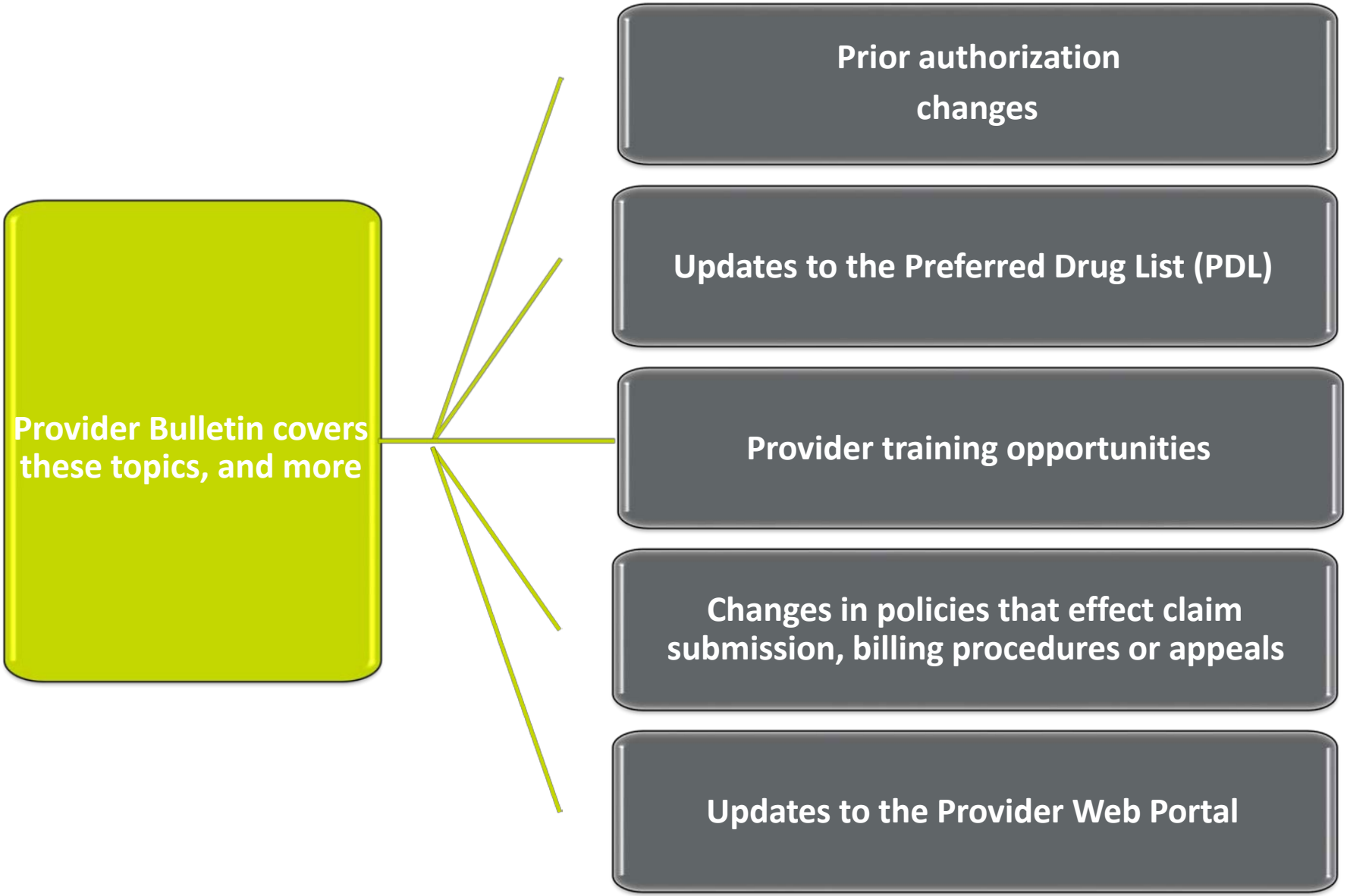
Marketplace

Medicare DSNP

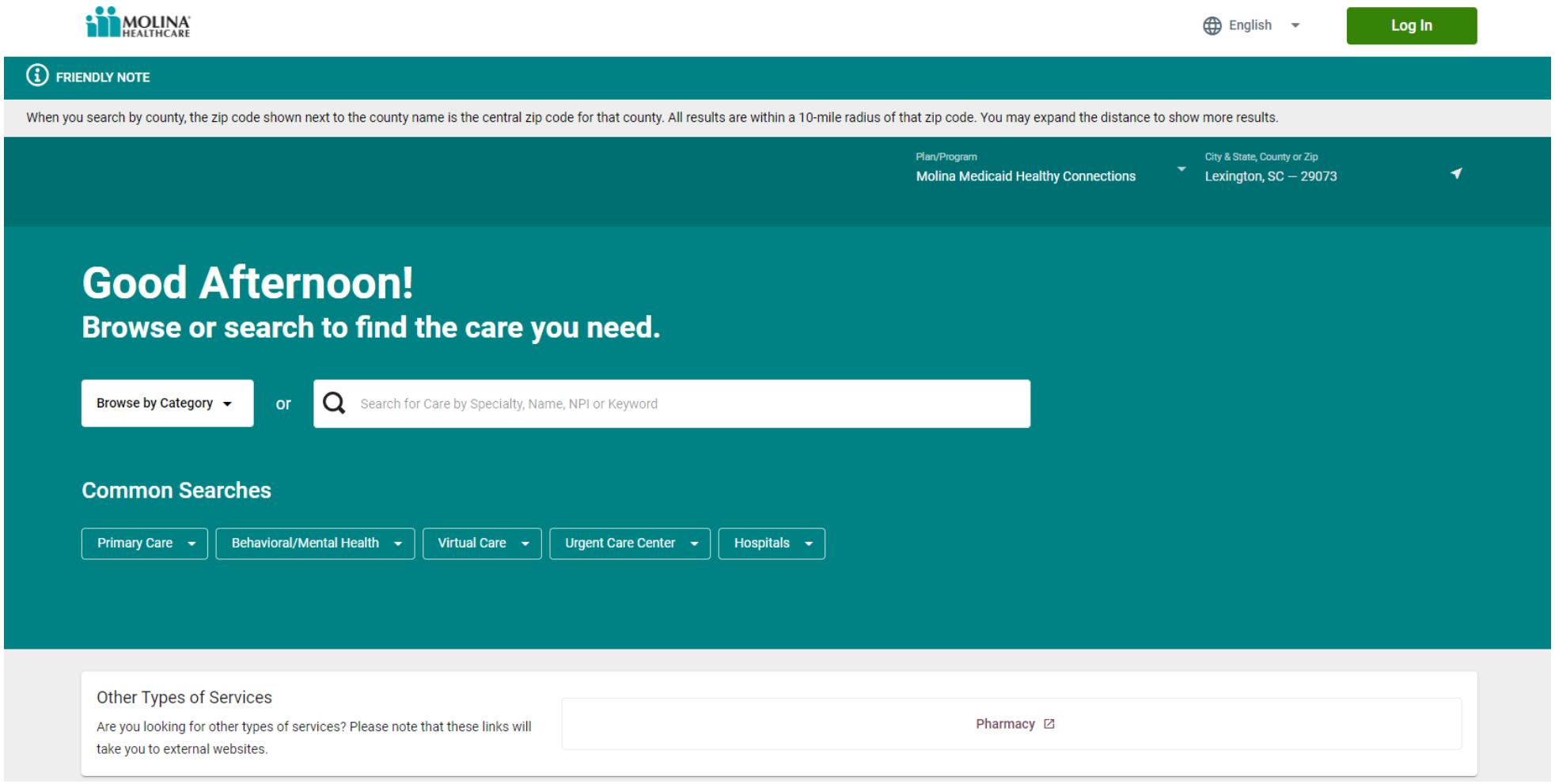


# Provider Bulletin

To keep you up-to-date on system improvements, process enhancements, required guidelines and more, Provider Newsletters are sent to Molina Healthcare's provider network. Sign up here.



# Provider Online Directory




There are now drop-down menus for the line of business and automatic location settings.

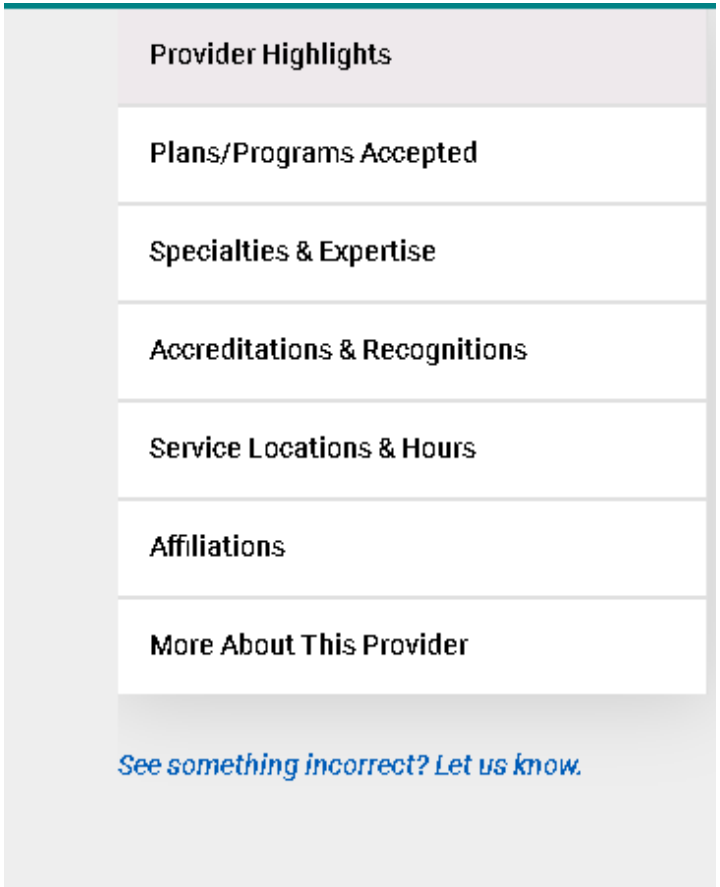
Click here for the link.

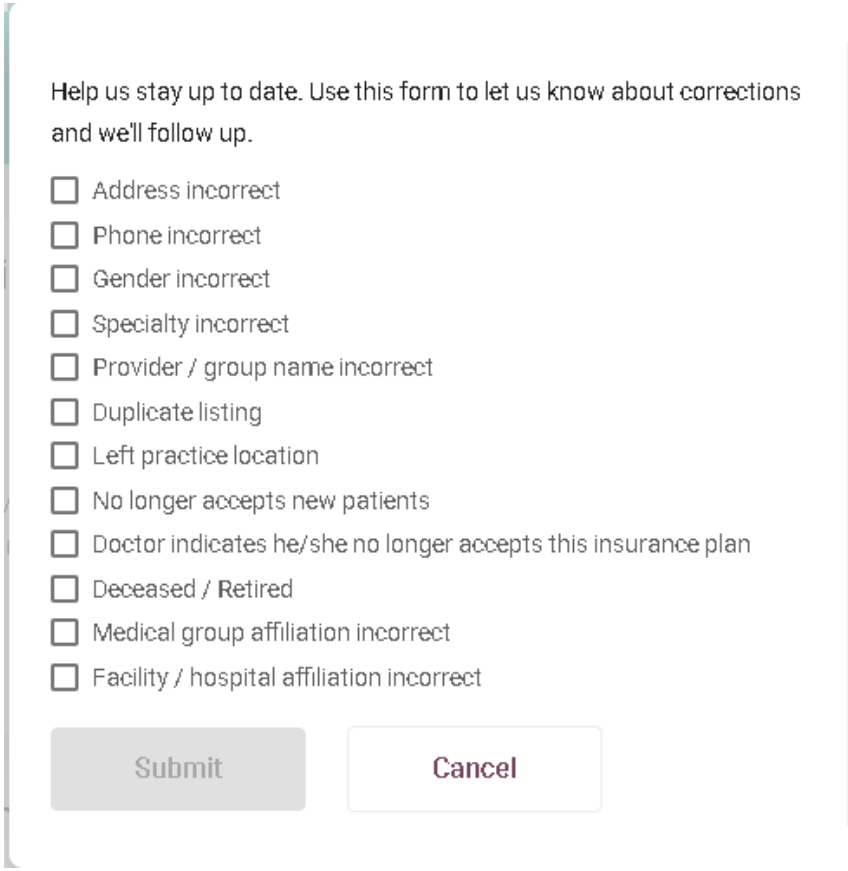
MOLINA HEALTHCARE

# Provider Online Directory

You can let us know if changes are needed to the directory online

https://molina.sapphirethreesixtyfive.com/?ci=sc-molina&network_id=31&geo_location=34.03899526959232,-81.00306997492193&locale=en_us



# Provider Resources – Availity (Our Provider Portal)

https://www.availity.com/molinahealthcare


Welcome to Availity, the new provider portal for Molina Healthcare Inc. (Molina)

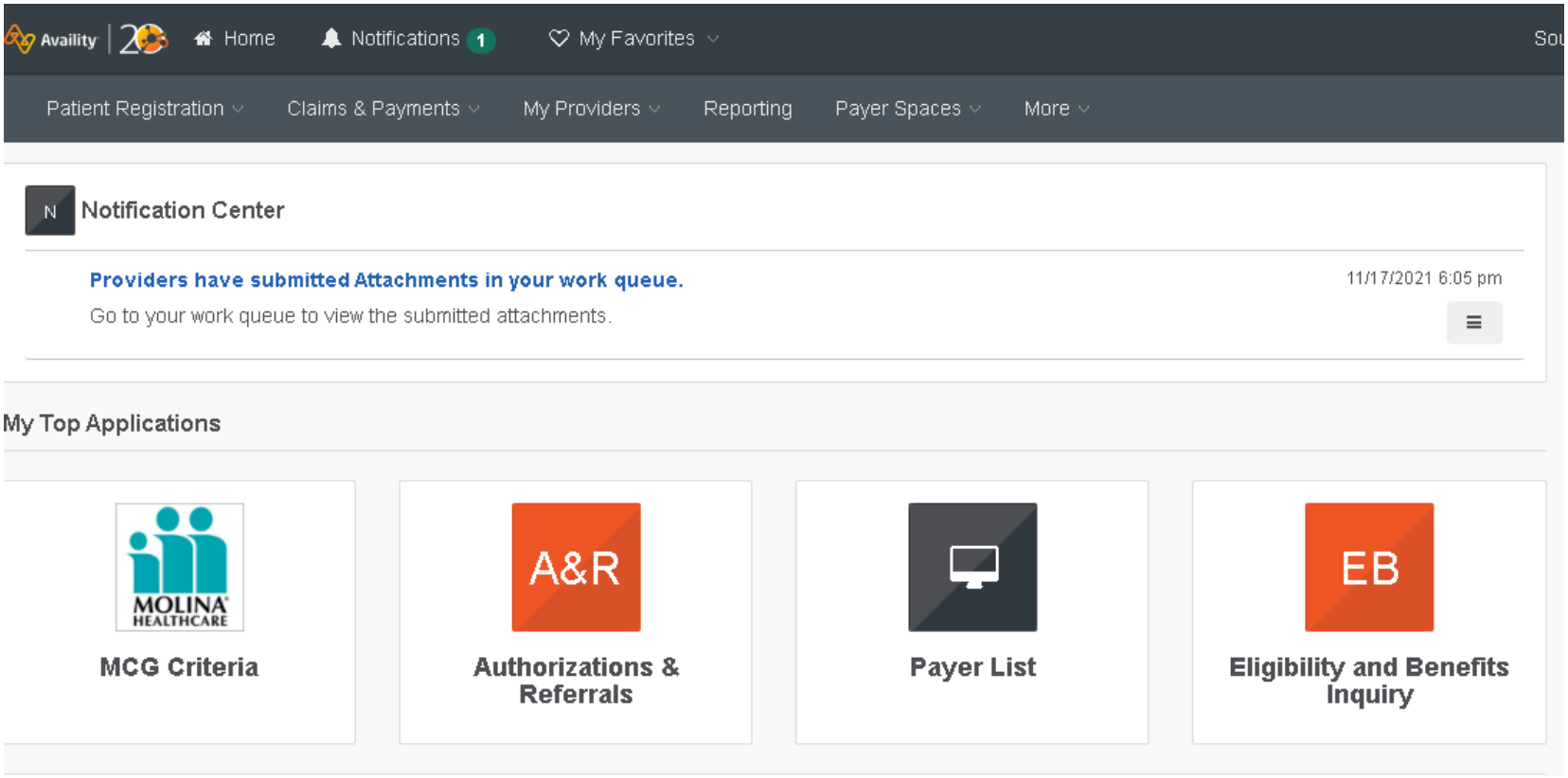
FAQs

Helpful Resources

Availity Portal User Guide

# Provider Resources –

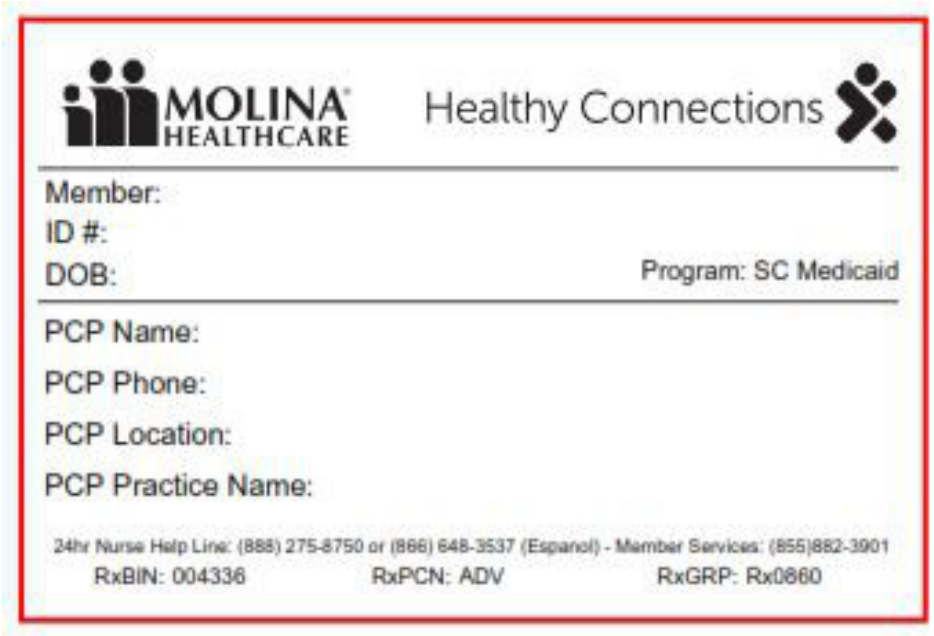
# Availity (Our New Provider Portal)




Core Features Available

Eligibility & benefits: Access to patient eligibility and benefits information including COB Claims & remits: View claims status, electronic remittance advices, attaching medical documents to claim

# Molina Healthcare Medicaid ID Card


MOLINA HEALTHCARE

Healthy Connections

Member:

ID #:

DOB:

Program: SC Medicaid

PCP Name:

PCP Phone:

PCP Location:

PCP Practice Name:

24hr Nurse Help Line: (888) 275-8750 or (866) 648-3537 (Espanol) - Member Services: (855)882-3901

RxBIN: 004336 RxPCN: ADV RxGRP: Rx0860

**MEMBERS:** If you have any questions, please visit our website at www.molinahealthcare.com or call Member Services at (855) 882-3901

**24 HOUR NURSE ADVICE LINE:** If you have questions about your health, call our 24 hour Nurse Advice Line at (888) 275-8750 or (866) 648-3537 (Espanol). For hearing impaired, call TTY 711 or (866) 735-2929.

**EMERGENCY SERVICES:** Call 911 (if available) or go to the nearest emergency room or other appropriate setting. If you are not sure whether you need to go the emergency room, call your Primary Care Physician (PCP) at the number on the front of this card for instructions. Follow up with your PCP after all emergency room visits.

**PRACTIONERS/PROVIDERS/HOSPITALS:** For prior authorizations, eligibility, claims or benefits visit the Molina Web Portal at www.molinahealthcare.com or call (855) 237-6178.

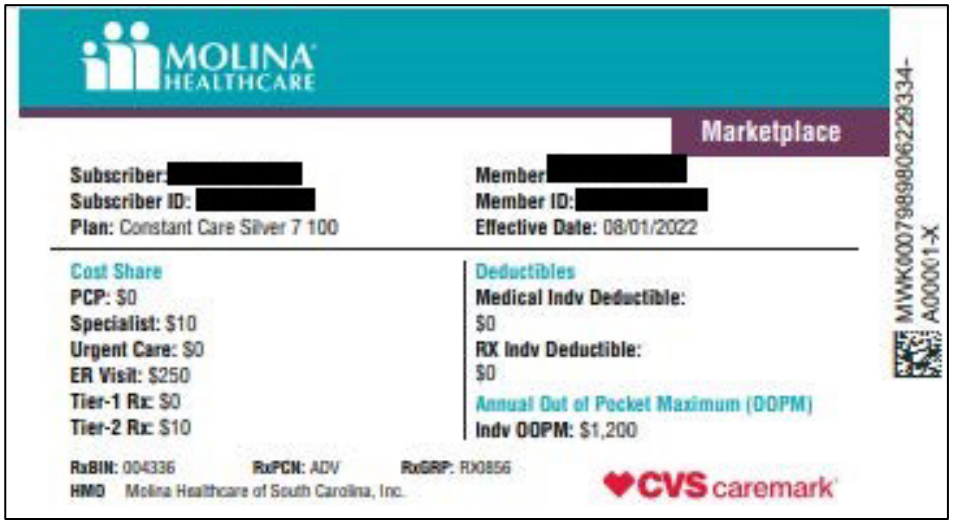
**PHARMACISTS:** For pharmacy authorization questions, please call (855) 237-6178.

Claims Submission: PO BOX 22664, Long Beach, CA 90801 - EDI Claims: Emdeon Payer ID: 46299

Molina Healthcare Address: 4105 Faber Place Drive, STE 120, Charleston, SC 29405

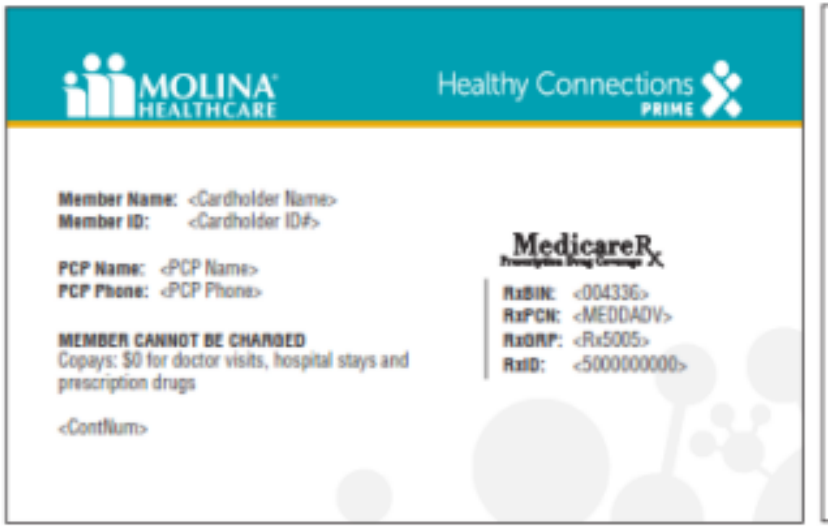
www.molinahealthcare.com

# Molina Healthcare Marketplace ID Card

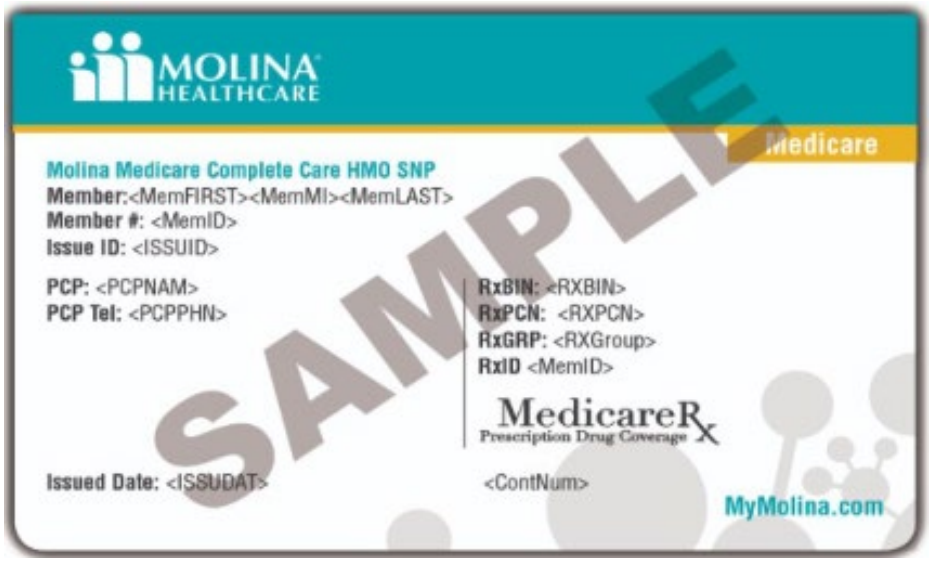



# Molina Healthcare MMP Dual ID Card

MMP – Sample Card

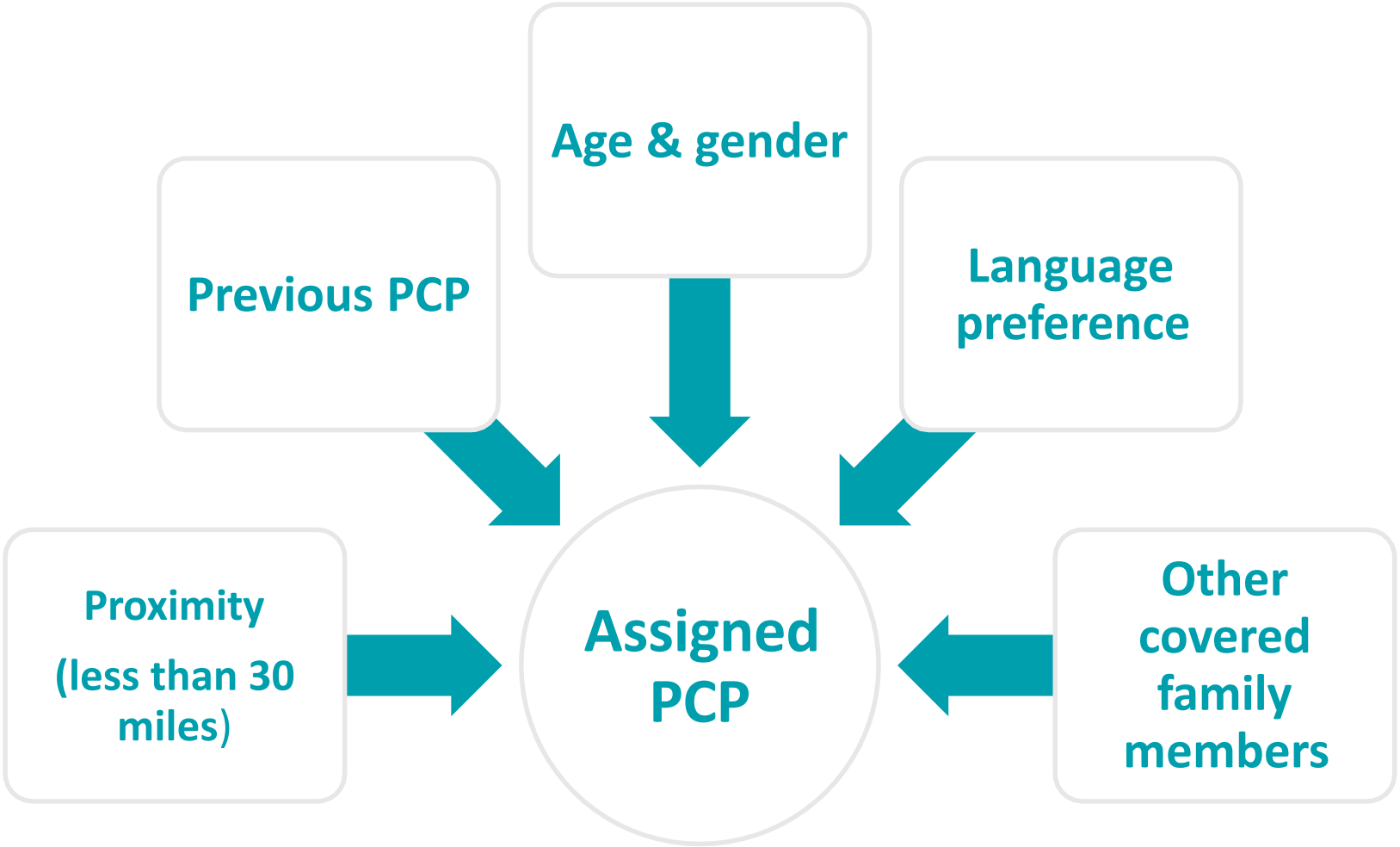



# Molina Healthcare Medicare DSNP ID Card




# PCP Assignment

**PCP Assignment** – Members have the right to choose their PCP. If the member or his/her designated representative does not choose a PCP, one will be assigned using:




MOLINA HEALTHCARE

# Changing Primary Care Providers

Members may change their PCP at any time through:

## Member Services

- (855) 882-3901 – 8 a.m. to 6 p.m. Monday-Friday
- For hearing impaired TTY/TDD 711

## Member Web Portal

- Register or log on at MyMolina.com.
- Members can change a PCP, request a new ID card, check eligibility and more.

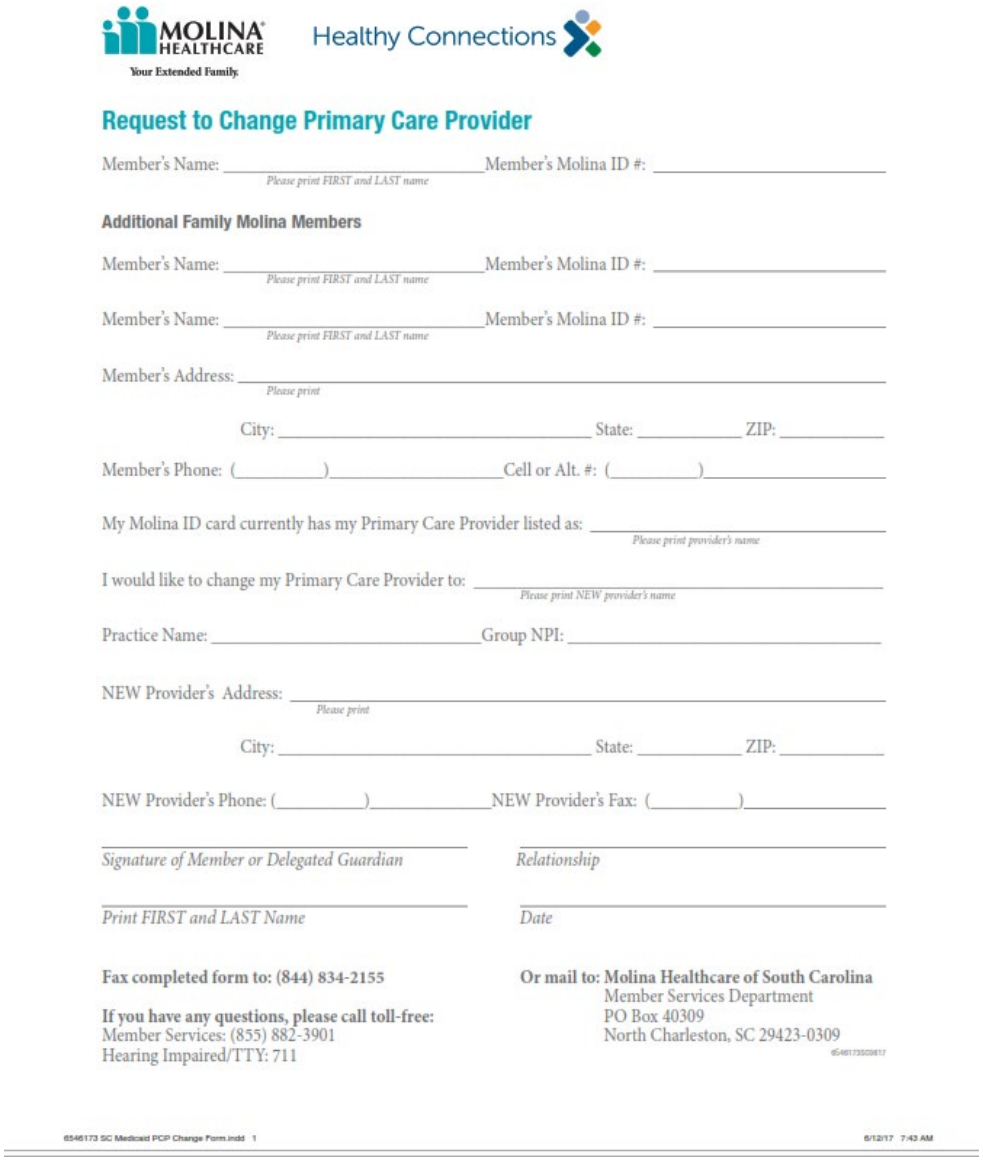
MOLINA HEALTHCARE

# Your provider Representative Can also Provide this form

Great to have with check-in paperwork.

Be sure you are getting credit

for the PCP services, you are doing.



MOLINA HEALTHCARE
Your Extended Family

Healthy Connections

## Request to Change Primary Care Provider

Member's Name: _____ Member's Molina ID #: _____
*Please print FIRST and LAST name*

**Additional Family Molina Members**

Member's Name: _____ Member's Molina ID #: _____
*Please print FIRST and LAST name*

Member's Name: _____ Member's Molina ID #: _____
*Please print FIRST and LAST name*

Member's Address: _____
*Please print*

City: _____ State: _____ ZIP: _____

Member's Phone: (_____)_____ Cell or Alt. #: (_____)_____

My Molina ID card currently has my Primary Care Provider listed as: _____
*Please print provider's name*

I would like to change my Primary Care Provider to: _____
*Please print NEW provider's name*

Practice Name: _____ Group NPI: _____

NEW Provider's Address: _____
*Please print*

City: _____ State: _____ ZIP: _____

NEW Provider's Phone: (_____)_____ NEW Provider's Fax: (_____)_____

_____ _____
*Signature of Member or Delegated Guardian* *Relationship*

_____ _____
*Print FIRST and LAST Name* *Date*

**Fax completed form to: (844) 834-2155**

**If you have any questions, please call toll-free:**
Member Services: (855) 882-3901
Hearing Impaired/TTY: 711

**Or mail to: Molina Healthcare of South Carolina**
Member Services Department
PO Box 40309
North Charleston, SC 29423-0309

6546173 SC Medicaid PCP Change Form.indd 1 6/12/17 7:43 AM

# Prior Authorizations (PA)

**Prior Authorization (PA)** 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
- Identify care management and disease management opportunities
- Improve coordination of care

Requests for services on the Molina Healthcare Prior Authorization Guide are evaluated by licensed nurses and trained staff. A list of services and procedures that require prior authorization, along with request forms are located on our website at **MolinaHealthcare.com**.

# Prior Authorization (PA)

**Information generally required to support decision making includes:**

- Current (up to six months), adequate patient history related to the requested services
- Physical examination that addresses the problem
- Lab or radiology results to support the request (including previous MRI, CT, lab or X-ray report/results)
- PCP or specialist progress notes or consultations
- Any other information or data specific to the request

**Molina Healthcare will process all "non-urgent" requests in no more than 14 calendar days from the initial request. "Urgent" requests will be processed within 72 hours of the initial request. If we require additional information, we will attempt to contact you (if timeframes allow).**

# Case Management (CM) and Transition of Care (TOC)

Molina's CM and TOC Program's involve collaborative processes aimed to meet the member's individual needs while promoting quality of life and obtaining the best possible care outcomes. To receive the right care at the right time, and in the right setting.

Conditions for CM:

- CHF
- Diabetes
- Asthma
- ESRD
- Sickle Cell
- BH
- Opioid Disorder Use
- Catastrophic and Chronic
- Conditions
- High Tech Home Care

(not inclusive list)


TOC Coach to aid Member:

- Exacerbation of Chronic condition post hospitalization
- Fragmentation of care
- Medication
- Member and Caregiver education

(not inclusive list)

**Referrals please call: (855) 237-6178**

# Quality Improvement

**Facilitating & encouraging preventive care for healthy members and those with chronic conditions**

- Pregnancy Rewards and Motherhood Matters℠ for new and expecting moms
- Focused diabetes, hypertension and asthma programs
- Prenatal care

- Targeted provider incentives
- Focused diabetes, hypertension and asthma programs
- Comprehensive support and educational material

**Provider Programs**

- HEDIS® and CAHPS® education and awareness
- Post-appointment member survey for feedback on member satisfaction with provider services

**(CAHPS®) Survey**

MOLINA® HEALTHCARE

# Access to Care Standards

In applying access standards, providers agreed they will not discriminate against any member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, place of residence, socioeconomic status, or status as a recipient of Medicaid benefits. Provider and contracted medical groups may not limit the practice because of a member's medical (physical or mental) condition or the expectation of frequent or high-cost care. If a PCP chooses to close his/her panel to new members, Molina Healthcare must receive 30 days advance written notice from the provider.

## Office Wait Times

- Not to exceed 45 minutes
- PCPs are required to monitor waiting times and adhere to standards

## After Hours Care

- Providers must have backup (on call) coverage 24/7
- May be an answering service or recorded message
- Must instruct members with an emergency to hang up and call 911 or go to the nearest emergency room

# Access to Care Standards

| Category | Type of Care | Access Standard |
|---|---|---|
| Primary Care Provider (General Practitioners, Internist, Family Practitioners, Pediatricians) | Preventive/Routine Care | Within four (4) weeks |
| | Urgent Care | Within forty-eight (48) hours |
| | Emergent Care | Immediately upon presentation at treatment site. |
| | After Hours | Available by phone 24 hours a day, seven days a week |
| Behavioral Health | Routine Care | Within ten (10) calendar days |
| | Urgent Care | Within forty-eight (48) hours |
| | Non-Life Threatening | Within six (6) hours |

NOTE: Important HEDIS measures for BH are:
Follow up of an acute BH hospitalization with a BH provider who can prescribe medications within 7 days post discharge. Follow up of Antidepressants, Antipsychotics, and ADHD meds at initiation and continuation phases. Diabetes screening in patient who are on antipsychotics.

# Preferred Drug List (PDL)

- The Molina Healthcare PDL was created to help manage the quality of our members' pharmacy benefit.
- The PDL is the cornerstone for a progressive program of managed care pharmacotherapy.
- Prescription drug therapy is an integral component of your patient's comprehensive treatment program.
- The PDL was created to ensure that members receive high quality, cost-effective and rational drug therapy.
- The Molina Healthcare of South Carolina PDL is available on our website at: MolinaHealthcare.com.

MOLINA HEALTHCARE

# Preferred Drug List

- The PDL is determined by a National Pharmacy and Therapeutics Committee which meets Quarterly.
  - Pharmacy staff
  - Chief Medical Officers
  - Participating Providers from the Molina

- Requests for review for additions or changes
  - Email those to your provider services representative. The SC CMO of Director of Pharmacy will submit to the committee
  - Please send supporting articles

# Pharmacy

Prescriptions for medications requiring prior approval or for medications not included on the Molina Healthcare Preferred Drug List may be approved when medically necessary and when PDL alternatives have demonstrated ineffectiveness.

When these exceptional needs arise, providers may fax a completed Prior Authorization/Medication Exception Request.

**PA Fax – Medicaid:**

**(888) 858-3090**

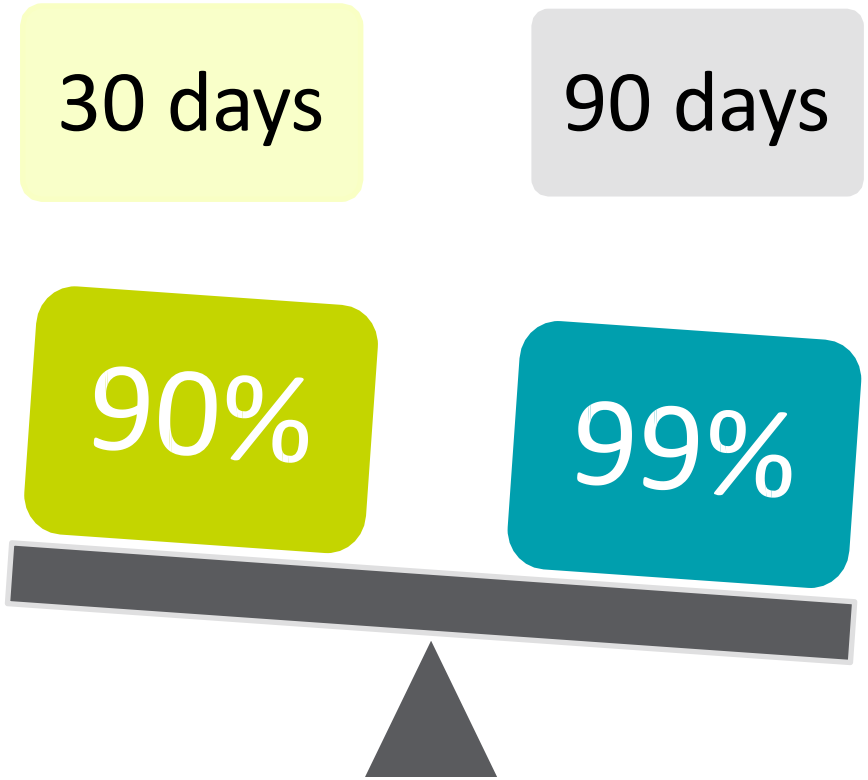
**PA Fax – Medicare:**

**(866) 290-1309**

# Claims Processing Standards

**Claims Processing Standards:** Claim payment will be made to contracted providers in accordance with the provisions set forth in the provider's contract. Further, payment is subject to the following minimum standards as set forth by SC DHHS.

- 90 percent of the monthly volume of clean claims will be adjudicated within 30 calendar days of receipt by Molina Healthcare.
- 99 percent of all claims shall be paid or denied within 90 calendar days of receipt by Molina Healthcare.



# Claims Submission Options

## Clearinghouse

EDI or electronic claims are processed faster than paper claims
Emdeon is the outside vendor used by Molina Healthcare
Providers may use any clearinghouse. Note that fees may apply.
Use payer ID: 46299
Emdeon phone: (877) 469-3269

## Provider Web Portal

- Online submission through the Web Portal at Log In to Availity®

## Paper claims directly to Molina Healthcare

- Attn: Molina Healthcare of South Carolina

PO Box 22664
Long Beach, CA 90801

MOLINA HEALTHCARE

# Claims Customer Service

| Corrected Claims | EDI Submission Issues | Claims Reconsiderations |
| --- | --- | --- |
| Can be submitted through the Provider Web Portal or EDI | Call the EDI customer service line at (866) 409-2935 | Use the Claims Reconsideration Form on our website |
| Providers have 120 days from the date of original remittance advice | Email to: EDI.Claims@MolinaHealthcare.com | Requests must be received within 90 days from the date of original remittance advice |
| Mail completed form and corrected claim to: P.O. Box 22712, Long Beach CA 90801 | Contact your Provider Services Representative | Fax (877) 901-8182<br>Mail – Attn: PIRR<br>P.O. Box 40309<br>N. Charleston SC 29423-0309 |

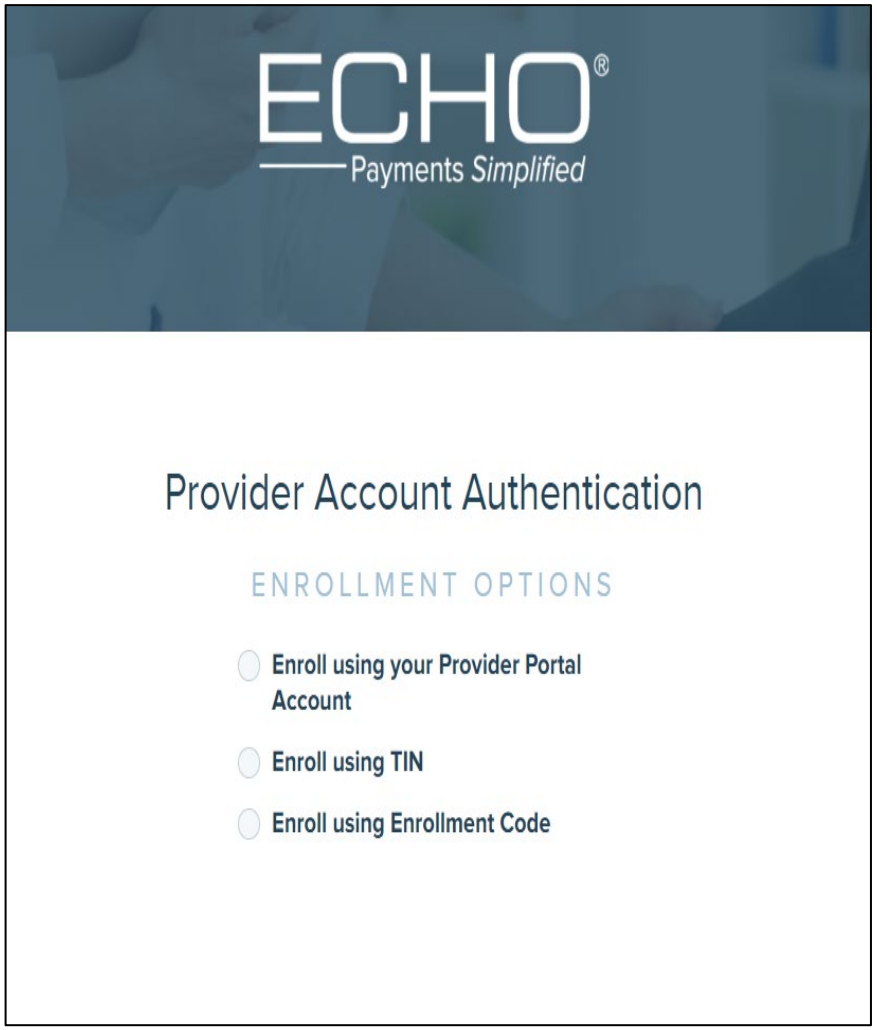
For help with any claims related process, contact Provider Services at (855) 237-6178.

MOLINA HEALTHCARE

# Electronic Payments and Remittance Advice

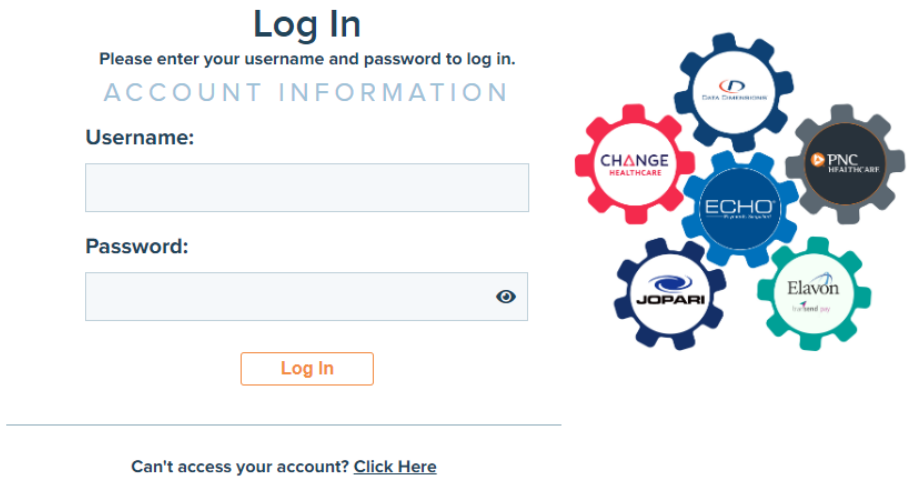
Molina Healthcare partnered with our payment vendor, **ECHO**, for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Access Is free.

[ECHO Health Provider Login (echohealthinc.com)]



# Electronic Payments and Remittance Advice

- Access Remits and 835 files via Providerpayments.com
- Register here







**Benefits of Echo**

- Administrative rights to sign up/manage your own EFT account Ability to associate new providers within your organization to receive EFT/835s
- View/print/save PDF versions of your Explanation of Payment (EOP) Historical EOP search by various methods (i.e. claim number, member name)
- Ability to route files to your FTP and/or clearinghouse

Echo Customer Service:
(800) 895-0621

MOLINA HEALTHCARE

# Balance Billing

Balance billing Molina members for covered services is prohibited other than the member's applicable copayment, coinsurance and deductible

The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.


## Examples of balance billing include:

- Requiring Molina Members to pay the difference between the discounted and negotiated fee and the Provider's usual and customary fees
- 
- Charging Molina Members fees for covered services beyond copayments, deductibles or Coinsurances

# Pre- Payment Audits - Optum

The purpose of conducting Pre-Pay reviews is to ensure that services billed are consistent with medical record documentation

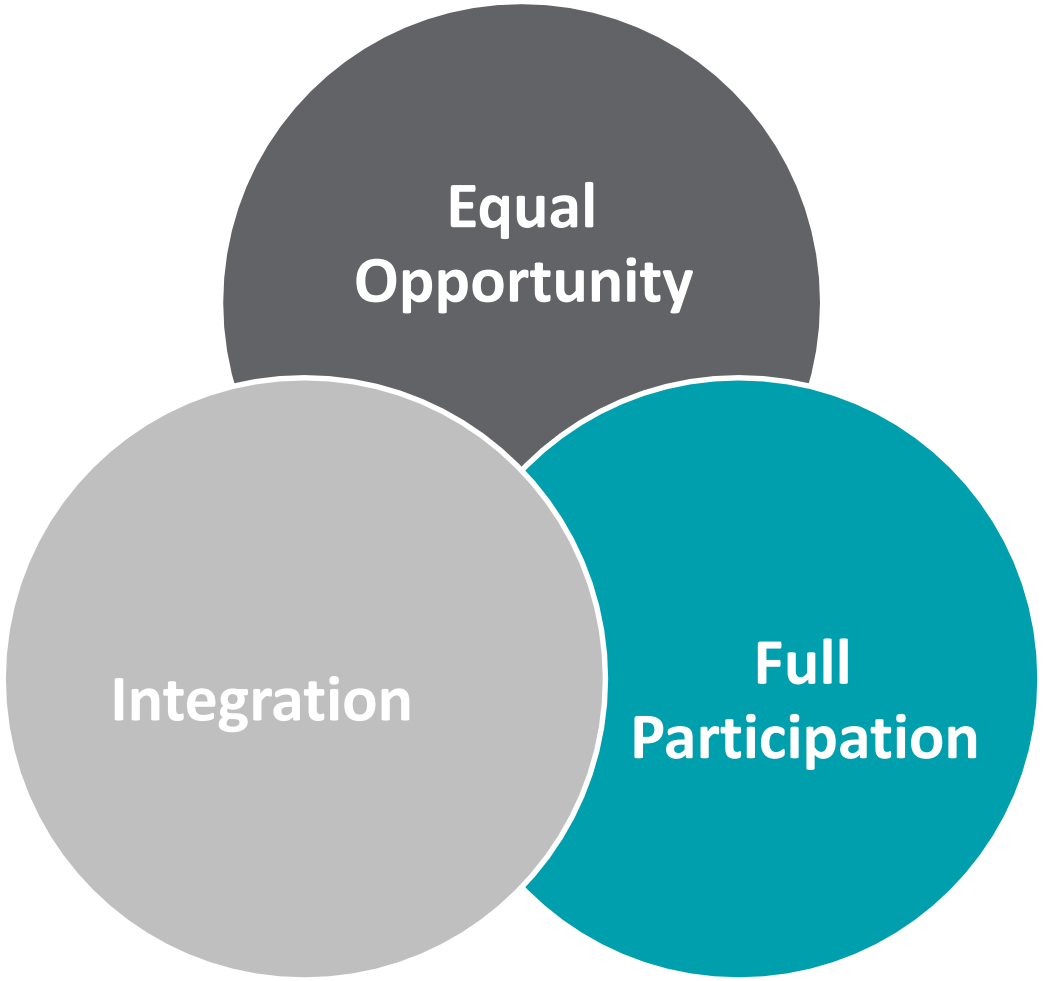
https://files.constantcontact.com/9a17b072601/321026b0-5f0f-4406-9b37-7fb2e5b6d5c1.pdf

| |
|---|
| What will be the Remit Code ? |
| The EOP will contain the following Remit Remark Code and Message referencing each line:<br>Remit Remark Code: M127 |
| What will be the Remit Message? |
| "Optum requesting Medical Records on Molina's behalf. The allowed timeframe for Medical Record submission and any disputes is based on timely filing requirements. Please direct questions regarding this Medical Record request to Optum at (877) 244-0403 |
| How will I submit Medical Records and what should I include? |
| Follow Optum Instructions of how to submit Medical Records and what to include – Submissions vary AURL Upload and Secure fax are options , please follow the instructions in the<br>Optum Resolution Team 877-244-0403 |

# Americans with Disabilities Act (ADA)

The ADA prohibits discrimination against people with disabilities, including discrimination that may affect employment, public accommodations (including health care), activities of state and local government, transportation, and telecommunications. The ADA is based on three underlying values:

Compliance with the ADA extends, expands, and enhances the experience for **ALL** Americans accessing health care and ensures that people with disabilities will receive health and preventive care that offers the same full and equal access as is provided to others.



# HIPAA

**The Health Insurance Portability and Accountability Act** (HIPAA) requires providers to implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of a member's **protected health information (PHI)**. Providers should recognize that identity theft is a rapidly growing problem and that their patients trust them to keep their most sensitive information private and confidential.

Molina Healthcare strongly supports the use of electronic transactions to streamline health care administrative activities. Providers are encouraged to submit claims and other transactions using electronic formats. Certain electronic transactions are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

- Claims and encounters
- Member eligibility status inquiries and responses
- Claims status inquiries and responses
- Authorization requests and responses
- Remittance advices

Molina Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers who wish to conduct HIPAA standard transactions with Molina Healthcare should refer to: HIPAA Transactions

# Fraud, Waste & Abuse

Molina Healthcare seeks to uphold the highest ethical standards for the provision of health care services to its members, and supports the efforts of federal and state authorities in their enforcement of prohibitions of fraudulent practices by providers or other entities dealing with the provision of health care services.

| Abuse | Fraud |
| --- | --- |
| Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicare and Medicaid programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicare and Medicaid programs. (42 CFR § 455.2) | An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR § 455.2) |

Do you have suspicions of member or provider fraud? The **Molina Healthcare AlertLine** is available 24 hours a day, seven days a week, and even on holidays at (866) 606-3889. Reports are confidential, but you may choose to report anonymously.

MOLINA HEALTHCARE

# Examples of Fraud, Waste & Abuse

Health care fraud includes, but is not limited to, the making of intentional false statements, misrepresentations or deliberate omissions of material facts from, any record, bill, claim or any other form for the purpose of obtaining payment, compensation or reimbursement for services.

## Member

- Lending an ID card to someone who is not entitled to it
- Altering the quantity or number of refills on a prescription
- Making false statements to receive medical or pharmacy services
- Using someone else's insurance card
  Including misleading information on or omitting information from an application for health care coverage or intentionally giving incorrect information to receive benefits
- Pretending to be someone else to receive services
- Falsifying claims

## Provider

- Billing for services, procedures or supplies that have not actually been rendered
- Providing services to patients that are not medically necessary
- Balance billing a Medicaid member for Medicaid covered services
- Double billing or improper coding of medical claims
- Intentional misrepresentation of benefits payable, dates rendered, medical record, condition treated/diagnosed, charges or reimbursement, provider/patient identity, treatments to receive payment, "upcoding," and Concealing patients misuse of ID card
- Failure to report patient's forgery/alteration of a prescription

# Cultural and Linguistic Expertise

National census data shows that the United States' population is becoming increasingly diverse. Molina has a thirty-year history of developing targeted healthcare programs for a culturally diverse membership and is well-positioned to successfully serve these growing populations by:

- Contracting with a diverse network of community-oriented providers who have the capabilities to address the linguistic and cultural needs of our members;
- Educating employees about the differing needs among Members; and
- Developing member education material in a variety of media and languages and ensure that the literacy level is appropriate for our target audience.

Additional Cultural and Linguistic Resources are available to providers such as:

- Low-literacy materials
- Translated documents
- Accessible formats (i.e. Braille, audio or large font)
- Cultural sensitivity trainings and cultural/linguistic consultation

# Cultural and Linguistic Expertise

*Providers are asked to participate in and cooperate with Molina's provider education and training efforts as well as member education and efforts. Providers are also asked to comply with all health education, cultural and linguistic, and disability standards, policies, and procedures.*

## Note – Interpretive Services

- MHSC has interpreter services on a 24 hour basis. Please contact Member Services toll-free at (**855) 882-3901** for more information.
- MHSC provides twenty four (24) hours/seven (7) days a week Nurse Advice Services for members. The Nurse Advice Line provides access to 24 hour interpretive services. Members may call Molina Healthcare's Nurse Advice Line directly (English line (888) 275-8750) or (Spanish line at (866) 648-3537) or for assistance in other languages. *The Nurse Advice TTY is (866) 735-2929.* The Nurse Advice Line telephone numbers are also printed on membership cards.

# Deficit Reduction Act

- The Deficit Reduction Act ("DRA") was signed into law in 2006. The law, which became effective on January 1, 2007 aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

- Health care entities like Molina Healthcare of South Carolina who receive or pay out at least $5 million in Medicare and Medicaid funds per year must comply with DRA. Providers doing business with Molina Healthcare of South Carolina, and their staff, have the same obligation to report any actual or suspected violation of Medicare and Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

  - The Federal False Claims Act and state laws pertaining to submitting false claims;
  - How providers will detect and prevent fraud, waste, and abuse;
  - Employee protected rights as whistleblowers.

- The Federal False Claims Act and the Medicaid False Claims Act have Qui Tam language commonly referred to as "whistleblower" provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims Act(s). The whistleblower may also file a lawsuit on their own. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

# Deficit Reduction Act

The Federal False Claims Act and the Medicaid False Claims Act contain some overlapping language related to personal liability. For instance, the Medicaid False Claims Act has the following triggers:

- Presents or causes to be presented to the state a Medicaid claim for payment where the person receiving the benefit or payment is not authorized or eligible to receive it
- Knowingly applies for and receives a Medicaid benefit or payment on behalf of another person, except pursuant to a lawful assignment of benefits, and converts that benefit or payment to their own personal use
- Knowingly makes a false statement or misrepresentation of material fact concerning the conditions or operation of a health care facility in order that the facility may qualify for certification or recertification required by the Medicaid program
- Knowingly makes a claim under the Medicaid program for a service or product that was not provided

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in furthering a false claim are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority
- Two times the amount of back pay plus interest
- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions.

Affected entities who fail to comply with the law will be at risk of forfeiting all Medicaid payments until compliance is met. Molina Healthcare of South Carolina will take steps to monitor our contracted providers to ensure compliance with the law.

# Frequently Used Phone Numbers

| DEPARTMENT | NUMBER |
|---|---|
| Prior Authorizations<br>8:00 a.m. – 5:00 p.m. | (855) 237-6178 Fax (866) 423-3889 |
| Radiology Authorizations | (855) 714-2415 ext. 72<br>Fax (877) 731-7218 |
| NICU Authorizations | (888) 562-5442 ext. 117453 or 114768<br>Fax (877) 731-7220 |
| Pharmacy Authorizations | (866) 467-5551 Fax (855) 571-3011 |
| Behavioral Health Authorizations | (855) 237-6178 Fax (866) 423-3889 |
| Member Customer Service<br>Benefits/Eligibility | (855) 882-3901 TTY/TDD 711 |
| Provider Customer Service<br>8:00 a.m. – 5:00 p.m. | (855) 237-6178 Fax (877) 901-8182 |
| 24 Hour Nurse Advice Line | English (844) 800-5155<br>TTY 711<br>Spanish (866) 648-3537<br>TTY 711 |
| Vision Care | March Vision: (844) 946-2724 |
| Dental | DentaQuest (888) 307-6552 |

**Provider Services**
(855) 237-6178
8 a.m. to 5 p.m.
Monday – Friday

**Member Services**
8 a.m. to 6 p.m.
Monday – Friday

To receive our Provider Bulletin via email, contact **SCProviderServices@MolinaHealthcare.com**

MOLINA HEALTHCARE

# Questions and Comments