
# *Molina Healthcare Non-Participating Guide for Providers*

Molina values provider partnerships and appreciates the family – like relationship that you pass on to our members. We wanted to assist in the process of this care by providing an overview for topics such as billing guidelines, prior authorizations, and claim submissions. If you are interested in becoming a contracted provider, please contact Molina Texas Provider Services at (855) 322-4080.

## Non-Participating Provider Billing Guidelines

### Prior Authorizations

All out-of-network services must be preauthorized by Molina Healthcare. Emergency services (as defined by Federal and State Law), local health departments, dialysis or OB/GYN services are excluded from the prior authorization requirements. An authorization does not guarantee payment, as a non-PAR provider must agree to a rate by signing a single case agreement for the claim to be paid.

Providers are encouraged to use the Molina Prior Authorization Form provided at MolinaHealthcare.com. If using a different form, providers are required to supply the following information, as applicable, for the requested service:

a. Member demographic information (Name, DOB, ID #, etc.).
b. Clinical information sufficient to document the Medical Necessity of the request services
c. Provider demographic information
d. Requested service/procedure (including specific CPT/HCPCS and ICD-10 Codes).
e. Location where the service will be performed.
f. Member diagnosis (CMS-approved diagnostic and procedure code and descriptions).
g. Pertinent medical history (include treatment, diagnostic tests, examination data).
h. Requests length of stay (for inpatient requests).
i. Indicate of request is for expedited or standard processing.

Molina will process any non-urgent requests within fourteen (14) calendar days of receipt of request. Urgent requests will be processed within seventy-two (72) hours of receipt of request.

Prior Authorization requests can be submitted via:

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| Fax | • UM Inpatient: (833) 994-1960<br>• UM Outpatient: (866) 420-3639<br>• Imaging/Transplant: (877) 731-7218<br>• BH Requests: (866) 617-4967<br>• LTSS Requests: (844) 304-7127<br>• Pharmacy J Code Requests: (888) 487-9251 |
| | • Medicare/MMP: (844) 251-1450<br>• Pharmacy Medicare/MMP J Code Requests: (866) 290-1309 |
| Phone | • Utilization Management:(855) 322-4080 |

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|---|---|
| | • Imaging/Transplant: (855) 714-2415<br>• BH Requests: (866) 449-6849<br>• Pharmacy Requests: (855) 322-4080 |
| Mail | Molina Healthcare of Texas<br>Attn: Healthcare Services Dept.<br>5605 N. MacArthur Blvd., Suite 400<br>Irving, TX 75038 |

**Claims Submissions**

To be eligible for Texas Medicaid reimbursement, a provider of health-care services (including an out-of-state provider) must be enrolled with Texas Medicaid & Healthcare Partnership (TMHP). All claims must be filled with the provider's National Provider Identifier (NPI). The provider's NPI must be attested with TMHHP.

Providers do not have to attest their NPI with TMHP to bill Molina on CHIP or Medicare members.

Paper Claims Guidelines

Non-electronic claims must be submitted to Molina on a CMS 1500 or UB-04 claim form that is legible and accurate within ninety-five (95) days of the date of service. Molina is also able to accept the UB92. Non-electronic claims that meet the requirements of a clean claim should be paid or denied within thirty (30) days of receipt. Claims that do not meet the clean claim requirements will still be paid or denied in a timely manner where possible, but Molina will not be liable for any late payment penalties on claims that do not meet the requirements of a clean claim.

Non-electronic claims should be mailed to:

Molina Healthcare
Attn: Claims
PO Box 22719
Long Beach, CA 90801

Electronic Claims Guidelines

Electronic claims must be submitted using the appropriate Professional and Institutional Encounter guidelines as shown below, and within 95 days of the date of service.

1. 837 Professional Combined Implementation Guide
2. 837 Institutional combined Implementation Guide
3. 837 Professional Companion Guide
4. 837 Institutional Companion Guide; or
5. National Council for Prescription Drug Programs (NCPDP) Companion Guide

Electronic claims that meet the clean claim requirements should be paid or denied within thirty (30) days of receipt (excluding Nursing Facilities). Claims that do not meet the requirements of a clean claim will still be paid or denied in a timely manner where possible, but Molina will not be liable for any late-payment penalties on claims that do not meet the requirements of a clean claim.

Molina accepts electronic claims through most major clearinghouses. Providers submitting claims electronically should use the **Payor ID 20554**.

It is important to track your electronic transmissions using your acknowledgement reports. The reports assure claims are received for processing in a timely manner. When you file your claims electronically, you should:

- Receive an acknowledgement from your current clearinghouse.
- Receive an acknowledgement from WebMB within five to seven business days of your transmission.
- Contract your local clearinghouse representative if you experience any problems with your transmission.

For additional information on Claims Submission Guidelines, refer to the Provider Manual located at MolinaHealthcare.com.

**Timely Filing**

Medicaid (STAR and STAR+PLUS), CHIP/CHIP Perinate and Marketplace claims for covered services must be filed within ninety-five (95) calendar days from the date of service.

Medicaid claims for covered services rendered to Molina Dual Options STAR+PLUS MMP enrollees must be filed within 95 days after the disposition by Medicare. Proper documentation is needed to verify the disposition date by Medicare.

**Balance Billing**

Providers contracted with Molina cannot bill the Member for any covered benefits beyond applicable copayments, deductibles, or coinsurance. (Note: there are no copayments, deductibles or coinsurance for Medicaid members.) The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider. Balance Billing a Molina Member for services covered by Molina is prohibited. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.

Members who are dually eligible for Medicare and Medicaid shall not be liable for Medicare Part A or B cost sharing when the State or another payer such as a Medicaid Managed Care Plan is responsible for

paying such amounts. Balance billing a Medicare and/or Medicaid Member for Medicare and/or Medicaid covered services is prohibited by Law.

**Texas Billing Rule**

When a service is a benefit of Medicare and Medicaid, and the client is covered by both programs, the claim must be filed with Medicare first. TMHP *must* receive Medicaid claims within 95 days of the date of Medicare disposition.

Medicare claims for covered services rendered to Molina Dual Options STAR+PLUS MMP enrollees must be filed within one (1) calendar year (365 days) from the date of service.

**Referrals**

Molina Healthcare will not approve referrals to non-contracted providers. A complete list of participating providers is available in the Molina Healthcare Provider Online Directory at MolinaHealthcare.com. You can also call Provider Services at (855) 322-4080 for assistance with finding a contracted provider.

**Benefits and Payment Policy**

Molina Healthcare's benefits and payment policies adhere to the standards and guidelines set by the Texas Medicaid & Healthcare Partnership (TMHP) and the Texas Health and Human Services Commission (HHSC). For more information, please visit http://www.tmhp.com/ or https://hhs.texas.gov/.

**Member Eligibility Verification**

Medicaid

Providers are responsible for requesting and verifying current Medicaid eligibility information by asking for the Your Texas Benefits Card and their Molina Healthcare Identification Card (ID card). The Member's Your Texas Benefits Card takes precedence over their Molina Healthcare ID card.

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the patient has current Medicaid coverage. Providers should verify the patient's eligibility for the date of service prior to services being rendered. There are several ways to do this:

- Swipe the patient's Your Texas Benefits Medicaid card through a standard magnetic card reader, if your office uses that technology.
- Use TexMedConnect on the TMHP website at www.tmhp.com.
- Call the Your Texas Benefits provider helpline at (855) 827-3747.
- Call Member Services at the patient's medical or dental plan.

CHIP

Providers may verify a Member's CHIP eligibility using the following methods:

- Checking the member's Molina ID Card
- Calling Molina Member Services at (866) 449-6849

- MESAV
- Checking the monthly PCP Eligibility listing
- Electronic eligibility verification e.g. NCPDP E1 Transaction (for Pharmacies only)
- Calling the CHIP Helpline at (877) 543-7669

MMP

Providers can call (855) 322-4080 to verify member eligibility.

**Contract Requests**

Providers who are interested in contracting with Molina Healthcare of Texas should complete the Provider Contract Request form, available at MolinaHealthcare.com.

**Single Case Agreements**

Single Case agreements are necessary when an eligible Molina member needs to receive services from a provider who is not contracted for the applicable line of business and will not accept 100% of the applicable fee schedule. All Marketplace non-PAR providers require a single case agreement.

## Important Contacts

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| **Provider Services (Medicaid, CHIP & MMP) – **PAR Providers Only***<br>Claims Status, Complaint & Appeals Status, Member Eligibility, Benefit Verification, Utilization Management, Quality Improvement, Prior Authorizations, Referrals | (855) 322-4080<br>MHTXProviderServices@MolinaHealthcare.com |
| **Behavioral Health Services (Medicaid, CHIP & MMP)**<br>Crisis Hotline<br>Behavioral Health Services | <br>(800) 818-5831<br>(866) 449-6849 |
| **Contracting -** How to join the network | TexasExpansionContracting@MolinaHealthcare.com |
| **Provider Complaints and Appeals** | Phone: (866) 449-6849/ Fax: (877) 319-6852<br>Molina Healthcare of Texas<br>Attn: Provider Complaints & Appeals<br>P.O. Box 165089<br>Irving, TX 75016 |
| **Electronic Claims Submission Vendors**<br>Availity, Zirmed, Practice Insight, SSI & Change Healthcare | Payor ID for All: 20554 |
| **Paper & Corrected Claims** | P.O. Box 22719<br>Long Beach, CA 90801 |
| **Pharmacy** | Phone: (866) 449-6849/Fax: (888) 487-9251 |
| **24-hour Nurse Advice Line** | (888) 275-8750 (English)<br>(866) 648-3537 (Spanish) |
| **STAR+PLUS Service Coordination** | (866) 409-0039 |
| **Member Services (Medicaid & CHIP)** | (866) 449-6849<br>(877) 319-6826 (CHIP Rural Service Area) |
| **Enrollee Services (MMP)** | (866) 856-8699 |
| **Medicaid Managed Care Helpline** | (800) 964-2777 |

# Contract Request Form (CRF)

(*Please print legibly.*)

**Thank you for your interest in becoming a Molina Healthcare Provider.** To ensure the proper contract and credentialing packet is generated, please complete this contract request form and return along with a current W-9 to fax number: 877-900-5655 Attn: Contracting Team or email form to: mhtcontractrequest@molinahealthcare.com

**Please Select Provider Type**

☐ Individual ☐ Group ☐ Ancillary ☐ Hospital ☐ SNF ☐ LTAC ☐ Urgent Care/ER

☐ Nursing Facility ☐ Assisted Living Facility ☐ _____ LTSS (*specify type)*

☐ Home Modification ☐ DME ☐ PT/OT/SP ☐ CORF/ORF ☐ Other (please specify) _____

☐ ***Check Here if Adding Provider to Existing Group (Please submit current group roster with request)***

Requestor Name: _____ Requestor Phone: _____

Requestor Email: _____ Requestor Fax: _____

Provider Name: _____ Group Name: _____

☐ ***Primary Care Provider designation***

**Business/Service Address:** _____
*(If additional locations please attach roster)*

City, State, Zip: _____

Office Phone: _____ Office Fax: _____

Office Email: _____

Web Address: _____

**Mailing Address:** _____
(*Contract will be emailed unless indicated here where to send)*

City, State, and Zip: _____

Contact Phone: _____ Contact Fax: _____

Contact Email: _____

**Billing Address:** _____
(*Please indicate if the Billing Address is the same as the Service or Mailing Address)*

City, State, Zip: _____

**Additional Provider/Group Information**

Specialty: _____ Taxonomy: _____

Tax ID: _____ Bill Type: ☐ CMS1500 ☐ UB04 ☐ Both

Ind. NPI/API: _____ Group NPI/API: _____

Ind. TPI: _____ Group TPI: _____

# Contract Request Form (CRF)

(*Please print legibly.*)

Ind. Medicare*:_____
*(*note: required for contracting)*

Group Medicare*:_____
*(*note: cannot create group contract if no group Medicare)*

Ind. CAQH: _____
*(if applicable)*

DADS Contract #:_____
*(if applicable)*

Date requested: _____

***Once completed form is submitted, please allow 3-5 business days for contract packet to be mailed. Included in the contract package will be an opportunity to provide us with more details about your office.***