



Molina Healthcare of Puerto Rico

Provider Orientation – April, 2015

Provider Orientation



The goal of this provider orientation is to ensure that you as a provider have a good understanding of Molina Healthcare of Puerto Rico, (“MHPR”) our policies and procedures, and the resources/tools available to assist you and your staff in our efforts in delivering high quality services to our members.

We appreciate and value your participation in Molina’s provider network and look forward to our partnership to deliver quality, patient-centered, culturally sensitive, accessible and integrated healthcare services to our members.



Our Story & Who We Are



In 1980, the late Dr. C. David Molina, founded Molina Healthcare with a single clinic and a commitment to provide quality healthcare to those most in need and least able to afford it. This commitment to providing access to quality care continues to be our mission today, just as it has been for the last 34 years.



Mission Statement

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

Vision Statement

Molina Healthcare is an innovative national health care leader, providing quality care and accessible services in an efficient and caring manner.

Core Values

We strive to be an exemplary organization:

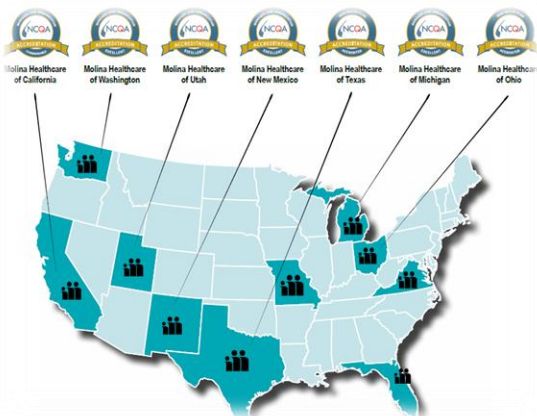
1. We care about the people we serve and advocate on their behalf.
2. We provide quality service and remove barriers to health services.
3. We are health care innovators and embrace change quickly.
4. We respect each other and value ethical business practices.
5. We are careful in the management of our financial resources and serve as prudent stewards of the public's funds.

This is the Molina Way

Recognized for Quality, Innovation and Success

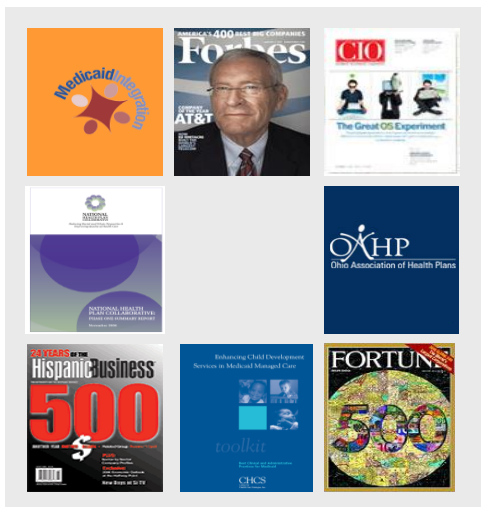


MOLINA HEALTHCARE Molina Healthcare Among the Nation's Best



Molina Healthcare, Inc.

- Molina Healthcare plans have been ranked among America's top Medicaid plans by U.S. News & World Report and NCQA.
- FORTUNE 500 Company by Fortune Magazine
- *Business Ethics* magazine 100 Best Corporate Citizens
- Alfred P. Sloan Award for Business Excellence in Workplace Flexibility in 2011
- Ranked as the 2nd largest Hispanic owned company by *Hispanic Business* magazine in 2009
- Recognized for innovation in multi-cultural health care by The Robert Wood Johnson Foundation
- Dr. J. Mario Molina, CEO of Molina Healthcare, was recognized by Time Magazine as one of the 25 most influential Hispanics in America



Online Resources



Molina offers a variety of on-line resources for our members and our providers:

- The Member Website - information available to all about Molina
- The Member Portal - specific information and tools available only to members (requires a log-on and password)
- The Provider Website – information available to all providers such as the Provider Manual, Clinical Guidelines and forms
- The Provider Portal – specific information and tools to assist providers such as eligibility verification, PCP member lists, and claims submission (requires a log-on and password)

Welcome to the Web Portal

The Web Portal is a secure area that provides multiple services now available to all Molina Providers both Medicaid and Medicare. In the Web Portal, you will be able to do the following:

- Check member eligibility and benefits
- Search and manage your service request/authorizations
- Search
- View
- Register services, easy on-

Provider Self Services

User ID:

Password:

[New Provider Registration](#)
[Request Access for new user New!](#)
[Minimum System Requirements](#)
[View FAQs](#)
[Contact Us](#)
 For technical assistance with this website please call **1-866-449-6848**

Online Resources - Provider



- Provider Manuals
- Provider Online Directories
- Web Portal
- Preventative & Clinical Care Guidelines
- Prior Authorization Information
- Advanced Directives
- Model of Care Training
- Claims Information
- Pharmacy Information
- HIPAA
- Fraud Waste and Abuse Information
- Frequently Used Forms
- Communications & Newsletters
- Member Rights & Responsibilities
- Contact Information

www.Molinahealthcare.com/PuertoRico

The screenshot shows the Molina Healthcare website for providers. It features a navigation bar with links for manual, forms, policies, HIPAA, EDI, drug list, health resources, communications, and contact us. The main content area includes a welcome message, a 'Welcome California Providers' section with a 'Provider Self Services' link, and a 'Sacramento County Low Income Health Program (LIHP)' announcement. There is also a '2013 Community Champion Nominations' section.

This section is titled 'Welcome to the Web Portal' and lists services available to providers. It includes a list of actions: 'Check member eligibility and benefits', 'Search and manage your service request/authorizations', 'Search', and 'View'. Below this is a 'Provider Self Services' login box with fields for 'User ID:' and 'Password:', an 'Accept & Login' button, and a 'Forgot Password?' link. At the bottom, there are links for 'New Provider Registration', 'Request Access for new user', 'New! Minimum System Requirements', 'View FAQs', and 'Contact Us', along with technical assistance contact information: '1-866-449-6848'.

This screenshot shows the 'Find A Provider' search interface. It includes a navigation bar with 'Home', 'Find a Pharmacy', 'Find A Provider', and 'Find A Hospital' buttons. The search form has three radio buttons for 'Search by City or Zip', 'Search by County', and 'Search Near Street Address'. Below these are dropdown menus for 'State*', 'City*', and 'Zip Code'. There are also dropdowns for 'Coverage*' and 'Provider Type*'. A 'More Search Options' section lists filters for Program, Specialty, Name, Language, Gender, Accept New Patients, By Hospital, and By Medical Group. A 'Show All Options' link is at the bottom. On the right, there is a 'Take a Tour' button and a video player.

Provider Manual and Highlights



MHPR's Provider Manual is written specifically to address the requirements of delivering healthcare services to our members, including your responsibilities as a participating provider. Providers may request copies of the MHPR Provider Manual by contacting your Provider Services Representative or you may view the manual on our provider website, at: www.molinahealthcare.com/PuertoRico

Provider Manual Highlights

- **Benefits and Covered Services Overview**
- **Claims, Encounter Data and Compensation (including the no balance billing requirements)**
- **Compliance and Fraud, Waste, and Abuse Program**
- **Contact Information**
- **Credentialing and Re-credentialing**
- **Utilization Management, Referrals and Authorizations**
- **Eligibility, Enrollment, and Disenrollment**
- **Healthcare Services**
- **Health Insurance Portability and Accountability Act (HIPAA)**
- **Interpreter Services**
- **Member Grievances and Appeals**
- **Member Rights and Responsibilities**
- **Model of Care**
- **Continuity of Care**
- **Preventive Health Guidelines**
- **Provider Responsibilities**
- **Quality Improvement**
- **Emergency Transportation Services**

Provider Directory



MHPR providers may request a copy of our MHPR Provider Directory from your Provider Services Representative(s), or providers may also use Molina's Provider On-line Directory (POD) located on our website.

To find a Medicaid provider, visit the online directory located on our Member website :www.psgmolinahealthcare.com and click:

- ✓ Find a Provider, or
- ✓ Find a Hospital, or
- ✓ Find a Pharmacy

The screenshot shows the ASES (Asegurando tu Salud) website's 'Find A Provider' search interface. At the top, there is a navigation bar with 'Home', 'Find A Pharmacy', 'Find A Provider', and 'Find A Hospital/Facility'. The 'Find A Provider' section is active. Below the navigation bar, there is a search area with a green header 'Enter Your Location' and a 'Quick Name Search' option. The search criteria are set to 'Search by City or Zip' with 'City*' set to 'PONCE' and 'Distance Within' set to '25 (miles)'. There are also fields for 'Near Zip Code*' and 'Coverage*'. Below the search area, there is a section 'Select a Coverage & Provider Type' with 'Coverage*' set to 'Plan de Salud de Gobierno' and 'Provider Type*' set to 'PRIMARY CARE PHYSICIAN'. At the bottom, there is a 'More Search Options' section with expandable options for 'Program', 'Specialty', 'Name, Language, Gender, Accept New Patients', 'By Hospital/Facility', and 'By Medical Group'. A 'Show All Options' link is also present. At the very bottom, there are 'Search', 'Clear', and 'Cancel' buttons.



MHPR participating providers may register for access to our Web Portal for self service member eligibility, claim status, provider searches, to submit requests for authorization and to submit claims.

The Web Portal is a secure website that allows our providers to perform many self-service functions 24 hours a day, 7 days a week.

Web Portal Highlights	
▪ Member eligibility verification and history	▪ Claims status inquiry
▪ View Coordination of Benefits (COB) information	▪ View Nurse Advice Line call reports for members
▪ Update provider profile	▪ View HEDIS® missed service alerts for members
▪ View/Download PCP Member Roster	▪ Status check of authorization requests
▪ Submit online service/prior authorization requests	▪ Submit claims online

Register online at <https://eportal.molinahealthcare.com/Provider/login>.

Molina Web Portal



- Claims Status Inquiry
- Create Professional Claim
- Open Incomplete Claim
- Export Claims Report to Excel
- Download Exported Claim File

Claims

Service Authorization

- Service Request/Authorization Status Inquiry
- Create Service Request/Authorization
- Open Incomplete Service Request/Authorization
- Create Service Request/Authorization Template

Member Eligibility Information (refer to next slide)



Your Extended Family

Member Eligibility Search



Click *Member Eligibility* from the main menu.

Search for a Member using Member ID First Name, Last Name and/or Date of Birth.

When a match is found, the web portal will display the member's eligibility and benefits page.

Home **MemberEligibility** Service Request/Authorization ProviderSearch *New* EligibilityListing Download Account Tools Logout [Help](#)

Reminder: Member Eligibility information is updated every 30 minutes

Eligibility searches are limited to Provider's state of business, except for Medicare which is available for all states. For eligibility questions, please contact [Molina Member Services](#)

NOTE - Eligibility verification is not a guarantee of payment.

Member Search Enter Member ID or First and Last Name and Date of Birth.

Member ID:

or

First Name: Last Name:

Date of Birth:
(mmddyyyy)

Search Options

Gender:

Zip Code:

Line of Business:

To see member eligibility from certain date enter date here: (mmddyyyy)

Verifying Member Eligibility



At no time should a member be denied services because he/she does not have a Molina ID Card or because his/her name does not appear on the eligibility roster. Members already enrolled with the GHP did not lose eligibility just because of the change of carriers.

MHPR offers various tools to verify member eligibility. Providers may use the online self service Web Portal, the integrated voice response (IVR) system, eligibility rosters or may speak with a Customer Service Representative.

- **Web Portal:** <https://eportal.molinahealthcare.com/Provider/login>
- **Customer Service/IVR Automated System:** (855) 558-5501

If a member does not appear on the eligibility roster, please contact the MHPR Customer Service center for further verification



Molina Healthcare Member Identification (ID) Card



Molina Healthcare of Puerto Rico ID Card (Front)



Beneficiario: Juan del Pueblo
Cubierta: 100-Federal
MPI: 1234567891234
Médico Primario: Medico de Pueblo



Fecha de efectividad.: 04/01/2015
Grupo Primario: Medico del Pueblo
Grupo Primario #: 0123
Parentesco: Asegurado Principal
BIN/PCN: 010868/HCR
Grupo Rx: GHMOL

Generalista: \$0
Especialista: \$0
Subespecialista: \$0
Hospital: \$0
Emergencia: \$0
Laboratorio: \$0
Rayos X: \$0
Farmacia: \$1/\$3

No se cobrará ningún copago a mujeres embarazadas ni a menores. Los copagos dentro de la Red Preferida son \$0.



Your Extended Family

Molina Healthcare Member Identification (ID) Card



Molina Healthcare of Puerto Rico ID Card (Back)



Beneficiario: Emergencias (24hrs):
Cuando una emergencia pueda resultar en su muerte o incapacidad, llame al 911 inmediatamente o vaya a la sala de emergencia más cercana. Los servicios de emergencia no requieren autorización previa.

Member: Emergencies (24hrs): When a medical emergency might lead to disability or death, call 911 immediately or go to nearest Emergency Room. No prior authorization is required for emergency care.

Proveedor: Notifique al Plan del Salud toda hospitalización de pacientes en un plazo de 24 horas.

www.psgmolinahealthcare.com

Servicios al beneficiario: (877) 335-3305

Línea de Consultas Médicas: (888) 620-1515
Línea libre de cargos disponible 24 horas al día, los 7 días de la semana

TTY: (787) 522-8281

Servicios al proveedor: (888) 558-5501

Esta tarjeta es solamente para propósitos de identificación y no es evidencia de que usted está certificado como elegible para recibir servicios de salud bajo el Plan de Salud del Gobierno. Esta tarjeta no podrá ser utilizada por cualquier otra persona que no sea el Participante del Plan de Salud del Gobierno identificado en la tarjeta.

This card is for identification purposes and does not prove eligibility for service. Enrollee ID Card may not be used under any circumstance by a person other than the identified enrollee.



Your Extended Family 14

The MHPR Preferred Provider (PPN) and General Network



Molina Healthcare of Puerto Rico is committed to improving access to health care for our members as follows:

- Primary care and preventive services are available from contracted primary care providers participating with MHPR in Primary Medical Groups (or “PMGs”).
- Along with the PMGs, MHPR’s Preferred Provider Network (or “PPN”) is our contracted provider network of specialists and other providers available for Members who are assigned to our contracted PMGs in the East and Southwest regions.
 - Example – Should MHPR have four hospitals and 500 specialists and ancillary providers in the PPN, all of those PPN providers will be listed and available to Members assigned to PMG #1, PMG#2, PMG#3 etc.
- The MHPR General Network will be composed of hospitals, ancillary and other providers that are (i) not part of the PMGs and PPN, and/or (ii) located outside of the East and Southwest service regions.
- Member Access and PCP processes are streamlined as follows:
 - No referral forms will be required for claims to be processed.
 - As a Managed Care Organization we encourage a written consultation/referral be provided first to the specialist by the PCP and subsequently by the specialist to the PCP in order to maintain proper and effective communication for the benefit of the member’s care.
 - No copays will apply to the PPN and General Network *for Medicaid and CHIP members*
 - Commonwealth membership will continue to pay applicable co-pays when going outside of the PPN.
 - Prescriptions within the approved formulary/PDL will not require a co-signature of the PCP if written by a contracted provider within the PPN.



The MHPR Preferred Provider (PPN) and General Network



- MHPR's provider directory will list the contracted PMGs along with our PPN and General Network providers
- The usual processes for referrals, co-pays and required co-signatures for prescriptions will apply for Members obtaining services from providers in the General Network or from out-of-network providers

MHPR Vendor Partners



MHPR is using several local companies to assist in the provision of benefits to our members

Vendor/Partner	Services
TeleMedik	Call Center, Nurse Advice Line, Disease Management/Case Management, Pre-Natal and EPSDT Outreach
Delta Dental	Dental Services
First Healthcare (FHC)	Behavioral Health
MedAdvantage	Credentialing
TransCita	Transportation (subject to limitations)

To contact these MHPR partners, please call the MHPR Provider Services Line:

888-558-5501

787-9994572



Provider Responsibilities



Access to Care Standards

- Molina Healthcare is committed to providing timely access to care for all members in a safe and healthy environment.
 - Molina Healthcare will ensure providers offer hours of operation no less than offered to commercial members.
 - Access standards have been developed to ensure that all health care services are provided in a timely manner.
 - The PCP or designee must be available (24) hours a day, seven days a week to members for emergency services. This access may be by telephone.
 - Appointment and waiting time standards are listed in Section of the Provider Manual.
 - Any member assigned to a PCP is considered his or her patient.

Hours of Service

- Network Providers are prohibited from having different hours and schedules for Molina members than what is offered to commercial Enrollees.
- Behavioral Health Facilities are required to have opening hours covering twelve (12) hours per day, seven (7) days per week and shall have available one (1) nurse, one (1) social worker and one (1) psychologist/psychiatrist.

Extended Schedule of Provider Medical Groups (PMGs)

- PMGs shall be available for services or consultations Monday through Friday of each Week, from 8:00 a.m. to 6:00 p.m. (Atlantic Time).
- In addition, each Provider that offers urgent care services, as well as any other qualified Provider willing to provide urgent care services, shall have sufficient personnel to offer urgent care services during extended periods Monday through Friday from 6:00 p.m. to 9:00 p.m. (Atlantic Time), in order to provide Members greater access to their PCPs and to urgent care services in each Service Region.
- PMGs may collaborate with each other to establish extended office hours at one (1) or multiple facilities.



Provider Responsibilities (cont'd)



Access to Care

Molina is committed to timely access to care for all members in a safe and healthy environment. Practitioners/providers are required to conform to the Access to Care appointment standards listed on the following slides to ensure that health care services are provided in a timely manner.

- The standards are based on 95% availability for emergency services and 80% or greater for all other services.
- The PCP or his/her designee must be available 24 hours a day, 7 days a week to members.

Membership Lists (Rosters)

- PCP offices may obtain their membership lists (aka rosters) on the Molina Healthcare Provider Portal
- PCPs may also contact our Provider Services call center team at 888-558-5501 to request their membership roster

Site and Medical Record-Keeping Practice Reviews

As a part of Molina Healthcare's Quality Improvement Program, providers are required to maintain compliance with certain standards for safety, confidentiality, and record keeping practices in their practices. For details regarding these requirements and other QI program expectations please refer to Section 8 of the MHPR Provider Manual.



Your Extended Family.

Provider Responsibilities (cont'd)



Member Information and Marketing

- Written informational and marketing materials directed at Molina Healthcare members must be developed at the fourth (4th) grade reading level and have prior written consent from Molina Healthcare and the appropriate government agencies. Please contact your Provider Services Representative for information and review of proposed materials.
- Neither Molina Healthcare, nor any contracted providers nor medical groups/IPA may:
 - Distribute to its members informational or marketing materials that contain false or misleading information
 - Distribute to its members marketing materials selectively within the Service Area
 - Directly or indirectly conduct door-to-door, telephonic, or other cold-call marketing for member enrollment

Provider Responsibilities (Cont'd)



The Role of Primary Medical Group (PMG) and Primary Care Physician (PCP):

The GHP Program uses a Coordinated Care Model in which patient (member) health is coordinated by a PCP. The PCP is responsible for evaluating the member periodically and coordinating all the health services the member may need. The PCP must keep an updated record of all of the services a member received.

The PCP is responsible to oversee and coordinate all aspects of the members' healthcare. The responsibilities of the PCP include:

- Perform medical assessments relevant to member's health
- To provide, coordinate and manage all health services and treatments that members need
- Provide preventive health services to keep members healthy
- Provide acute care when members are ill
- Inform members when he/she believes it is necessary that they visit a specialist or sub- specialist
- Provide referrals when necessary;
 - if a member should visit a specialist or sub-specialist outside of the Preferred Provider Network or
 - when a member requests want a second opinion
- Coordinate visits to specialists or sub-specialists outside the Preferred Provider Network
- Provide the prescriptions for member's medications or the orders for treatments
- Keep member's medical records updated with all the information on their health conditions, medications, treatments, etc.
- Consult with other health professionals about member's diagnosis and treatment.
- Administer the Ages and Stages Questionnaire ("ASQ") to the parents of child Enrollees. This questionnaire must be completed when the child is nine (9), eighteen (18), and thirty (30) months old, or at any other age established by the Health Department.
 - Forms will be available through the Molina Healthcare website.

Provider Responsibilities (cont'd)



Special Coverage Registration

- Physicians must notify Molina Healthcare immediately upon identification of a Molina Enrollee diagnosed with a condition that is within the scope of the Special Coverage Benefit.
 - The physician shall submit to Molina Healthcare the Special Coverage Registration Form (included in Appendix B and available on the Molina website) within one (1) working day of the Enrollee having been screened and diagnosed with a qualifying condition . (See Section 2, Benefits and Covered Services for a list of the diagnoses within the scope of the benefit).
 - Providers shall enter all applicable information on the form.
 - The treatment plan for the member is to be submitted with the Registration Form
 - The treatment plan and form should be faxed to Molina Healthcare of Puerto Rico at **(855) 378-3541**

Member Cost Sharing

Cost Sharing is the Deductible, Copayment, or Coinsurance that members must pay for Covered Services provided under the Government Health Plan. It is the provider's responsibility to collect the copayment and other member Cost Share from the member. The amount of the copayment and other Cost Sharing will be deducted from the Molina Healthcare payment for all claims involving Cost Sharing. Providers may not charge members fees for covered services beyond copayments or coinsurance. Additional information regarding Member Cost Sharing is available in Section 4 of the MHPR Provider Manual..

Relocations and Additional Sites

Providers should notify Molina Healthcare sixty (60) days in advance when they relocate or open an additional office. When this notification is received, a site review of the new office may be conducted before the provider's recredentialing date.



Provider Responsibilities (cont'd)



Appointment Access

All practitioners/providers who oversee the member's health care are responsible for providing the following appointments to Molina members in the timeframes noted:

Primary Care Practitioner (PCP)	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Adult Routine Physical Exams	Routine physical exams shall be provided for Enrollees age twenty-one (21) and over within thirty (30) Calendar Days of the Member's request for the service, taking into account both the medical and Behavioral Health need and condition
Primary Care	Routine evaluations for Primary Care shall be provided within thirty (30) Calendar Days, unless the Member requests a later time;
Pediatric Routine Care	Periodic screens ("EPSDT Checkups") in accordance with the Puerto Rico Medicaid Program's periodicity schedule and the American Academy of Pediatrics EPSDT periodicity schedule.
After Hours Care	After-Hours Instruction/Standards
After hours emergency instruction	"If this is an emergency, please hang up and dial 911"
After-Hours Care	Available by phone twenty-four (24) hours/seven (7) days



Provider Responsibilities (cont'd)



Behavioral Health

Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Non-life Threatening Emergency Care (Crisis)	Behavioral Health crisis services, face-to-face appointments shall be available within two (2) hours; and Detoxification services shall be provided Immediately according to clinical necessity
Urgent Care	Behavioral Health Care outpatient appointments for urgent conditions shall be available within twenty-four (24) hours
Routine Care	Within ≤ ten (10) calendar days

Other Providers

Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Specialist	Specialist Services shall be provided within thirty (30) Calendar Days of the Enrollee's original request for service
Dental Providers	Dental services shall be provided within sixty (60) Calendar Days following the request, unless the Enrollee requests a later date



Provider Responsibilities (cont'd)



<p>Diagnostic Laboratory, Diagnostic Imaging and Other Testing</p>	<p>Diagnostic laboratory, diagnostic imaging and other testing appointments shall be provided consistent with the clinical urgency, but no more than fourteen (14) Calendar Days, unless the Enrollee requests a later time.</p> <p>Diagnostic laboratory, diagnostic imaging and other testing, if a “walk-in” rather than an appointment system is used, the Enrollee wait time shall be consistent with severity of the clinical need</p>
<p>Prescription Fill Time</p>	<p>The in-person prescription fill time (ready for pickup) shall be no longer than forty (40) minutes. A prescription phoned in by a practitioner shall be filled within ninety (90) minutes</p>
<p>Follow-up Visits</p>	<p>The timing of scheduled follow-up outpatient visits with practitioners shall be consistent with the clinical need</p>
<p>Urgent Diagnostic Laboratory, Diagnostic Imaging and Other Testing</p>	<p>Urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability shall be consistent with the clinical urgency, but no longer than forty-eight (48) hours</p>
<p>Urgent Care Providers - Primary Medical, Dental</p>	<p>Primary medical, dental, and Behavioral Health Care outpatient appointments for urgent conditions shall be available within twenty-four (24) hours</p>
<p>Emergency Providers</p>	<p>Emergency Services shall be provided, including Access to an appropriate level of care, within twenty- four (24) hours of the service request</p>



Referrals and Prior Authorization



Referrals to a Specialist are made when medically necessary services are beyond the scope of the PCPs practice

Information is to be exchanged between the PCP and Specialist to coordinate care of the patient.

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

Requests for services listed on the Molina Healthcare of Puerto Rico Prior Authorization Guide are evaluated by licensed nurses and trained staff that have authority to approve services.

A list of services and procedures that require prior authorization is included in our Provider Manual and will also be posted on our website at: www.Molinahealthcare.com/PuertoRico

Request for Authorization



- Authorization for elective services should be requested with supporting clinical documentation at least 5 business days prior to the date of the requested service. Authorization for emergent services should be requested within one business day. Information generally required to support decision making includes:
 - Current (up to 6 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
- Standard Authorization Decisions – For standard authorization decisions, provide notice as expeditiously as the member's health condition requires and within regulatory time frames that may not exceed fourteen (14) calendar days following receipt of the request for service.
- Expedited Authorization Decisions – ***For cases in which a Provider indicates, or MHPR determines, following the standard time frame could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function,*** MSC will make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three (3) business days after receipt of the request for service.
- Providers who request prior authorization approval for patient services and/or procedures can request to review the criteria used to make the final decision. Providers may request to speak to the Medical Director who made the determination to approve or deny the service request.
- Upon receipt of prior authorization, MHPR will provide you with a Molina unique authorization number. This authorization number must be used on all claims related to the service authorized.
- Our goal is to ensure our members are receiving the *Right Services at the Right Time AND in the Right Place*. You can help us meet this goal by sending all appropriate information that supports the member's need for services when you send us your authorization request.
- Please contact us for any questions/concerns.



Service Request Form



Providers should send requests for prior authorizations to the MHPR Utilization Management Department using the Molina Healthcare Service Request Form which is available on our website at:
www.Molinahealthcare.com/PuertoRico

Service Request Forms may be called in or faxed to the Utilization Management Department to the numbers listed below, or submitted using our Provider Web Portal.

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

Phone: (888) 558-5501, please follow the prompts for prior authorization
Fax: (855) 378-3641



Prescription Drug Services



- MC - 21 is the Pharmacy Benefit Manager (PBM) for Molina Healthcare of Puerto Rico members
- The MC - 21 Help Desk can be reached 24/7, 365 days/year at the following #s :
 - 1-888-311-6001 or
 - 1-866-311-6001

Information regarding the Preferred Drug List (PDL can be found at)
<http://abarcahealth.com/clients/government/ases>

Claims



Third Party Liability

- Molina Healthcare as payer of last resort will make every effort to determine the appropriate Third Party payer for services rendered. Molina may deny claims when a Third Party has been established and will pay claims for covered services when probable Third Party Liability (TPL) has not been established or third party benefits are not available to pay a claim. Molina Healthcare will attempt to recover any third-party resources available to members and shall maintain records pertaining to TPL collections on behalf of members for audit and review.

Claims Processing Standards:

- On a monthly basis, over 90% of Medicaid claims received by Molina from our health plan network providers are processed within 30 calendar days; 100% of claims are processed within 45 working days. These standards have to be met in order for Molina to remain compliant with regulatory requirements and to ensure that our providers are paid in a timely manner.

Note : EDI (Electronic Claims) are processed more quickly than paper claims

Electronic Claims Submission Options

- Submit claims directly to Molina Healthcare of Puerto Rico via the Provider Portal
- Submit claims to MHPR via Immediata or Assertus
- Submit claims to MHPR via Emdeon
 - Emdeon is an outside vendor that is used by Molina Healthcare of Puerto Rico
 - When submitting EDI Claims to Molina Healthcare of Puerto Rico, please utilize **Payer ID # 81794**



Claims Addresses



Paper Claims Submission Address

Molina Healthcare of Puerto Rico
P.O. Box 364828
San Juan, Puerto Rico 00936-4828

EDI Claims Submission Information

Emdeon Payor ID# 81794
Emdeon Telephone (877) 469-3263

EDI Claim Submission Issues

Please call the EDI customer service line at (866) 409-2935 and/or
submit an email to EDI.Claims@molinahealthcare.com
or contact your provider services representative



Balance Billing and Claims Payment



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

Your Provider Agreement with MHPR 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 MHPR 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.

Claims Submission



Providers billing Molina Healthcare electronically should use the current HIPAA compliant ANSI X12N format

- 837I for institutional claims,
- 837P for professional claims, and
- 837D for dental claims) and
- use **electronic payor ID number: 81794.**

Providers must use good faith effort to bill Molina Healthcare for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility claims, the date of discharge. The following information must be included on every claim:

Institutional Providers:

The completed UB 04 data set or its successor format adopted by the National Uniform Billing Committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC. Entries stated as mandatory by NUBC and required by federal statute and regulations and any state designated data requirements included in statutes or regulation.

Physicians and Other Professional Providers:

The Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format. Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD) codes. Entries stated as mandatory by NUCC and required by federal statute and regulation and any state designated data requirements included in statutes or regulations.



Your Extended Family

Claims Submission



Timely Claim Filing

Providers shall promptly submit to Molina Healthcare claims for Covered Services rendered to members.

- All claims shall be submitted in a form acceptable to and approved by Molina Healthcare, and shall include any and all medical records pertaining to the claim if requested by Molina Healthcare or otherwise required by Molina Healthcare's policies and procedures.
- Claims must be submitted by provider to Molina Healthcare ***within 90 calendar days*** after the following have occurred: discharge for inpatient services or the date of service for outpatient services; and provider has been furnished with the correct name and address of the member's health maintenance organization.
- If Molina Healthcare is not the primary payer under coordination of benefits or third party liability, provider must submit claims to Molina Healthcare ***within 90 calendar days*** after 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 within these timelines shall not be eligible for payment, and provider hereby waives any right to payment therefore.

Electronic Funds Transfer & Remittance Advice (EFT & ERA)



MHPR has partnered with our payment vendor, FIS ProviderNet, for Electronic Funds Transfer and Electronic Remittance Advice. Access to the ProviderNet portal is FREE to our participating providers and we encourage you to register after receiving your first check from MHPR.

New ProviderNet User Registration:

1. Go to <https://providernet.adminisource.com>
2. Click “Register”
3. Accept the Terms
4. Verify your information
 - a. Select Molina Healthcare from Payers list
 - b. Enter your primary NPI
 - c. Enter your primary Tax ID
 - d. Enter recent claim and/or check number associated with this Tax ID and Molina Healthcare
5. Enter your User Account Information
 - a. Use your email address as user name
 - b. Strong passwords are enforced (8 or more characters consisting of letters/numbers)
6. Verify: contact information; bank account information; payment address
 - a. Note: any changes to payment address may interrupt the EFT process
 - b. Add any additional payment addresses, accounts, and Tax IDs once you have logged in.

If you are associated with a Clearinghouse:

1. Go to “Connectivity” and click the “Clearinghouses” tab
2. Select the Tax ID for which this clearinghouse applies
3. Select a Clearinghouse (if applicable, enter your Trading Partner ID)
4. Select the File Types you would like to send to this clearinghouse and click “Save”

If you are a registered ProviderNet user:

1. Log in to ProviderNet and click “Provider Info”
2. Click “Add Payer” and select Molina Healthcare from the Payers list
3. Enter recent check number associated with your primary Tax ID and Molina Healthcare

BENEFITS

- 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 associated Clearinghouse

If you have questions regarding the actual registration process, please contact ProviderNet at: (877) 389-1160 or email: Provider.Services@fisglobal.com



Claims Corrections/Disputes



Corrected Claims

Corrected claims are considered new claims.

- Corrected claims may be submitted electronically with the appropriate field on the 837 I or 837 P completed.
- Paper corrected claims need to be marked as corrected and should be submitted to the following address (subject to timely filing requirements):

Molina Healthcare of Puerto Rico, Inc.
PO BOX 364828
San Juan, PR 00936-4828

Claims Disputes/Adjustments

Providers seeking a redetermination of a claim previously adjudicated must request such action within ninety (90) days of Molina Healthcare's original remittance advice date. Additionally, any claim(s) dispute requests (including denials) should be submitted to Molina Healthcare using the standard claims reconsideration review form (CRRF). This form can be found on the provider website.

In addition to the CRRF, providers should submit the following documentation:

- The previous claim and remittance advice, any other documentation to support the adjustment and a copy of the Service Authorization form (if applicable) must accompany the adjustment request.
- The claim number clearly marked on all supporting documents



Claims Corrections/Disputes



Claims Disputes/Adjustments (cont'd)

These requests shall be classified as a “ Claims Dispute/Adjustment” and may be faxed to 844-488-7050. Requests may also be sent to the following address:

Molina Healthcare of Puerto Rico, Inc.
Attention: Provider Claims Disputes / Adjustments
PO Box 365068
San Juan, PR 00936-5068

Requests for adjustments of claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original claim.

The Provider will be notified of Molina Healthcare of Puerto Rico’s decision in writing within **thirty (30)** calendar days of receipt of the Claims Dispute/Adjustment request. Providers may request a claim dispute/adjustment when the claim was incorrectly denied as a duplicate or due to claims examiner or data-entry error.

Care Management Program/Model of Care



To ensure that members receive high quality care, Molina uses an integrated system of care that provides comprehensive services to all members across the continuum of Medicaid benefits. Molina strives for full integration of physical health, behavioral health, long term care services and support and social support services to eliminate fragmentation of care and provide a single, individualized plan of care for members. Molina's Care Management program consists of four programmatic levels. This approach emphasizes high-touch, member-centric care environment and focuses on activities that support better health outcomes and reduces the need for institutional care.

As a network provider, you play a critical role in providing quality services to our members. This includes identifying members in need of services, making appropriate/timely referrals, collaborating with Molina case managers on the Individualized Care Plan (ICP) and Interdisciplinary Care Team meetings (ICT; if needed), reviewing/responding to patient-specific communication, maintaining appropriate documentation in member's medical record, participating in ICT/ Model of Care provider training and ensuring that our members receive the right care in the right setting at the right time.



Please call Molina when you identify a Member who might benefit from such services.

For additional Model of Care information, please visit our website at :
www.Molinahealthcare.com/PuertoRico



Interdisciplinary Care Team - ICT



Molina's ICT may include:

- Registered Nurses (RNs)
- Social Workers
- Case Managers
- Utilization Management Staff
- Molina's Medical Director
- Pharmacy Staff
- Member's Primary Care Provider
- Member and/or Designee
- Care Transition Coach
- Service Providers
- Community Health Workers
- Other entity that member selects

Note: Molina's ICT is built around the member's preferences and decisions are made collaboratively and with respect to member's right to self-direct care. Members have the right to limit and/or may decline to participate in:

- Case management
- Participate in ICT and/or approve all ICT participants
- ICT meetings; brief telephonic communications

Care Management



Based on the level of Care Management needed, outreach is made to the member to determine the best plan to achieve short and long-term goals. Each level of the program has its own specific health assessment used to determine interventions that support member achievement of short- and long-term goals. At the higher levels, this includes building an individualized care plan with the member and/or representative. These assessments include the following elements based on NCQA, state and federal guidelines:

- Health status and diagnoses
- Cultural and linguistic needs
- Caregiver resources
- Body Mass Index, Smoking
- Communication barriers with providers
- Emergency Department and inpatient use
- Psychosocial needs (e.g., food, clothing, employment)
- Health goals
- Chemical dependency
- Readiness to change and Member's desire / interest in self-directing their care
- Life-planning activities (e.g., healthcare power of attorney, advance directives)
- Activities of daily living, functional status, need for or use of any Long Term Services and Supports (LTSS)
- Clinical history, Medications prescribed
- Visual and hearing needs
- Available benefits and community resources
- Confidence
- Treatment and medication adherence
- Primary Care Physician visits
- Durable medical equipment needs
- Mental health

The resulting care plan is approved by the member, maybe reviewed by the ICT and maintained and updated by the Case Manager as the member's condition changes. The Case Manager also addresses barriers with the member and/or caregiver, and collaborates with providers to ensure the member is receiving the right care, in the right setting, with the right provider.

Behavioral Health

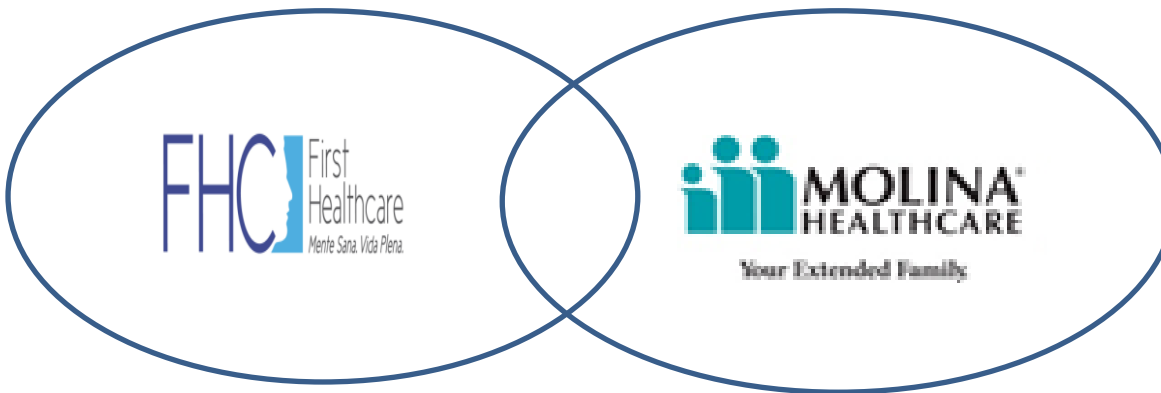


Why Molina Healthcare Chose to Partner with FHC

- FHC provides a local community knowledge base for our MHPR members and behavioral health providers
- FHC and Molina Healthcare share similar processes, clinical objectives and goals
- FHC is URAC Accredited with extensive experience providing behavioral health management services

Important Contact Numbers

- Government Health Plan Clinical Call Center - 855-822-5111
- Government Health Plan Provider Call Center - 855-580-2880
- FHC Provider contracting - 877-684-4339





FHC Has Clinical Staff Dedicated To MHPR

- Psychiatrists: Board Certified, credentialed, available on call 24/7
 - 3 Full time Psychiatrists on staff
 - Provider access line – 1-855-580-2880
- Care Access staff: available 24/7; all staff have at least a Bachelor's degree
 - Note : telephonic case managers are licensed social workers or psychologists*
 - 15 MHPR-dedicated staff in addition to existing staff

Members can be connected through the Molina Healthcare of Puerto Rico Member Services Line:
1-877-3353305 or 1-787-625-3874

Behavioral Health



MPHR – Dedicated Staff

- The UM staff have either a Current Unrestricted Registered Nurse (R.N.) License, a Social Work license, or are Licensed Psychologists
 - 3 MPHPR dedicated staff in addition to the existing hospital-based UM staff
- The Case Management staff are licensed Social Workers or Psychologists
 - 8 MPHPR dedicated staff in addition to existing region specific staff
 - Members can be referred to Case Management through the general member phone number.



Special Coverage/Specific Behavioral Health Conditions

- More extensive package of services than the Basic Coverage package
 - Members are eligible by “registering”
- Additional services are available for the diagnosis and treatment of certain behavioral health conditions outside of traditional outpatient therapy





Co-Location and Reverse Co-Location

- Co-Location - Primary Care Group Plan
 - MHPR will ensure continuity of care by leveraging Primary Care Groups (PMGs) that have mental health professionals on staff
 - MHPR will ensure that independent providers are also contracted to provide mental health services in those groups/offices that do not have those services available at the present time
 - Offices with logistic challenges will be partnered with behavioral health clinics and/or providers in their proximity
 - A designated Case Manager will work with the PMGs to facilitate coordination of care



Co-Location and Reverse Co-Location

- Reverse Co-Location - Behavioral Health Clinic Plan:
 - FHC is establishing behavioral health clinics with PCP coverage in 5 contracted areas. They are leveraging existing clinics and building in other areas.
 - FHC will use their established outpatient clinics located within contracted BH facilities that include medical professionals on staff
 - MHPR Medical Directors will be available 24/7 for guidance and consultation with PMG providers
 - A designated FHC Case Manager dedicated to MHPR will work with clinics to facilitate coordination of care and be available for on site consultation as needed



Co-Location Strategies

Member expresses depression to PCP during regular office visit

PCP Office with Limited Space

- PCP Calls FHC for BH referral and has member sign ROI
- Local FHC CM notified and member assessed for CM needs
- Member connected with participating provider in BH clinic within close proximity and ROI signed for PCP and/or PCP offered consult with FHC MD

BH Provider co-located within PMG

- Member referred to BH provider in PMG group
- Local FHC CM notified and member assessed for CM needs
- If psychiatric services are needed and BH provider in PMG is not prescriber, member referred to participating psychiatrist within close proximity and/or PCP offered consult with FHC MD

Case is discussed in integrated rounds with PCP, BH provider and FHC CM present. Integrated Care Plan completed. Referred for ICT as needed



The Molina Healthcare Partnership Principle:

To provide a comprehensive integrated delivery system through

- MHPR Behavioral Health Director
- Specific identified contacts for referrals between MHPR and all its partners
- Interdisciplinary care team meetings will be facilitated by the Molina Behavioral Health Director
- Joint staffing and rounds participation
- Direct hotlines that are integrated into the Molina call options
 - Provider hotline at FHC – for all providers to assist with consultation, referral and care coordination
 - Member crisis hotline
 - Member care coordination and customer services

Quality Improvement



Quality is a Molina Healthcare core value and ensuring members receive the right care in the right place at right time is everyone's responsibility. Molina's quality improvement department maintains key processes and continuing initiatives to ensure measurable improvements in the care and service provided to our members. Clinical measures and service quality are measured/evaluated/monitored through the following programs:

- Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Health Plan Survey (CAHPS®), and other quality measures
- Provider Satisfaction Surveys
- Health Management Programs:
 - Breathe with ease asthma program, Healthy Living with Diabetes, Chronic Obstructive Pulmonary Disease program, Heart-Healthy Living Cardiovascular program, Motherhood Matters pregnancy program to support and educate members and to provide special care to those with high risk pregnancy
 - Preventive Care and Clinical Practice Guidelines

For additional information about MHPR's Quality Improvement initiatives you can visit our website:

www.Molinahealthcare.com/PuertoRico



Disability, Literacy and Competency Training



Chronic Conditions and Access to Services

MHPR members may have numerous chronic health conditions that require the coordination and provision of a wide array of health care services. Chronic conditions within this population include, but are not limited to: cardiovascular disease, diabetes, congestive heart failure, osteoarthritis, and mental health disorders. These members can benefit from Molina's integrated care management approach. If you identify a member in need of such services, please make the appropriate/timely referral to our case management team. This will also allow us to continue to expand access for this population to not only Primary Care Providers but also Mental Health Providers, Community Supports and Medical Specialists. Access must be easy to understand and easy to navigate. This will improve the quality of health for our members.

Prejudices

Physicians and other health professionals who encounter people with disabilities in their professional practice should be aware not only of the causes, consequences, and treatment of disabling health conditions, but also of the incorrect assumptions about disability that result from stigmatized views about people with disabilities that are common within society. Providers shall not differentiate or discriminate in providing Covered Services to any Member because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, disability, physical, sensory or mental health handicap, socioeconomic status, chronic medical condition or participation in publicly financed programs of health care.

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: equal opportunity, integration, and full participation. 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.

Please refer to Molina Provider Education Series document – Americans with Disabilities Act (ADA) Questions & Answers for Healthcare Providers brochure for additional information on the ADA.

Disability, Literacy and Competency Training



Section 504 of the Rehabilitation Act of 1973

A civil rights law that prohibits discrimination on the basis of disability in programs and activities, public and private, that receive federal financial assistance. Section 504 forbids organizations and employers, such as hospitals, nursing homes, mental health centers and human service programs, from excluding or denying individuals with disabilities an equal opportunity to receive program benefits and services. Protected individuals under this law include: any person who (1) has a physical or mental impairment that substantially limits one or more major life activities, (2) has a record of such an impairment or (3) is regarded as having such an impairment. Major life activities include walking, seeing, hearing, speaking, breathing, learning, working, caring for oneself, and performing manual tasks. Some examples of impairments which may substantially limit major life activities, even with the help of medication or aids/devices, are: AIDS, alcoholism, blindness or visual impairment, cancer, deafness or hearing impairment, diabetes, drug addiction, heart disease, and mental illness.

For additional information or questions on ADA, please contact our “Bridge2Access Connections” at (877) Molina7.

Barriers

By reducing or eliminating barriers to health care access, we can improve health and quality of life for people with disabilities. Some of the most prevalent barriers for seniors and people with disabilities are:

- Physical Access: Ability to get to, in to, and through buildings
- Communication Access: Ensuring that a sign language or foreign language interpreter is present
- Medical Equipment Access: Ability to safely transfer on tables, access to diagnostic equipment
- Attitudinal: opinions and/or prejudices about a persons quality of life; embracing the idea that disability, chronic conditions and wellness exist simultaneously.

Another barrier to accessing healthcare may be related to out of pocket expenses, utilization management, and care coordination. These barriers effect our members more often than others because of limited incomes, high utilization of health care services, limited education and complexities of the system.

Molina Healthcare makes every effort to ensure that our providers are accessible and make accommodations for people with disabilities. For questions or further information is needed [i.e. materials in accessible format (large size print, audio, and Braille), need sign language or interpreter services], please contact our Member Services Department or “Bridge2Access Connections” at (877) Molina7.



Disability, Literacy and Competency Training



Person-Centered Model of Care

A team based approach in which providers partner with patients and their families to identify and meet all of a patient's comprehensive needs. The purpose of a Person-Centered Model of Care is to provide continuous and coordinated care to maximize health outcomes while involving the patient in their own health care decisions.

Planning

Services and supports should be planned and implemented with each member's individual needs, preferences and health care decisions in mind. Member's should be given the authority to manage their health care and supports as they wish with as much or as little assistance as they need. All necessary information should be given to the member so that they can make the best decision for themselves. Individuals should also have the freedom of choice when it comes to Provider selection.

Self-Determination

Self-determination can be defined as the process when individuals with disabilities and their families control decisions about their health care and have a say in what resources are used to support them. Self-determination can foster independent living for members and can also improve quality of life.

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.

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

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

Note – Interpretive Services

- MHPR has interpreter services on a 24 hour basis. Please contact Member Services toll-free at (855) 766-5462 for more information.

Fraud, Waste, & Abuse



MHPR 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.

“Fraud” means 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)

“Waste” means health care spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs to the Medicaid program.”

“Abuse” means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program, 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 Medicaid programs. (42 CFR § 455.2)

False Claims Act, 31 USC Section 3279



The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

The term “knowing” is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
- Acts in reckless disregard of the truth or falsity of the information in a claim.

False Claims Act, 31 USC Section 3279



The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

Penalties: \$5,500.00 up to \$11,000.00 per claim plus up to triple the amount of the claim in damages

- Criminal and/or civil prosecution & imprisonment
- Suspension/loss of provider license
- Exclusion from the Medicaid program/Government Contracts

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 Medicaid programs.

Health care entities like Molina Healthcare of Puerto Rico who receive or pay out at least \$5 million in (delete Medicare and) Medicaid funds per year must comply with DRA. Providers doing business with Molina Healthcare of Puerto Rico, and their staff, have the same obligation to report any actual or suspected violation of (delete 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 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 (FCA) is a federal statute that covers fraud involving any federally funded contract or program, including the Medicaid program. The FCA applies to all federally funded programs. Under the FCS, a violation is defined as any individual or entity that :

- 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 Puerto Rico will take steps to monitor our contracted providers to ensure compliance with the law.



Anti-Kickback Statute



The Anti-Kickback Statute (42 U.S.C. §§ 1320a-7b) is a federal law that prohibits persons from directly or indirectly offering, providing or receiving kickbacks or bribes in exchange for goods or services covered by Medicare, Medicaid and other federally funded health care programs. These laws prohibit someone from knowingly or willfully offering, paying, seeking or receiving anything of value (“remuneration”) in return for referring an individual to a provider to receive services, or for recommending purchase of supplies or services that are reimbursable under a government health care program.

For purposes of the Anti-Kickback Statute, “remuneration” includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

Violations of the law are punishable by criminal sanctions including imprisonment and civil monetary penalties. The individual or entity also may be excluded from participation in Medicare or other federal health care programs for violating the Anti-Kickback Statute.

Other Relevant Federal FWA Laws



- **Self-Referral Prohibition Statute (Stark Law)**
 - This law prohibits physicians from referring Medicaid & Medicare patients for certain designated health services (DHS) to an entity in which the physician or the physician's immediate family has a financial relationship unless an exception applies. Violations of the law are punishable by a civil penalty up to \$15,000 per improper claim, denial of payment, and refunds for certain past claims.
- **Civil Monetary Penalties Law**
 - The federal Civil Monetary Penalties Law covers an array of fraudulent and abusive activities and is similar to the False Claims Act. Violations of the law may result in penalties between \$10,000 and \$50,000 and up to three times the amount unlawfully claimed.

Entities/Individuals Excluded from Government Programs



No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the Office of Inspector General.

MHPR and contracted entities are required to check the OIG and General Services Administration (GSA) exclusion lists for ***all new employees*** and monthly thereafter to validate that employees and other entities that assist in the administration or delivery of services to Medicaid beneficiaries are not included on such lists.

OIG List of Excluded Individuals/Entities (LEIE): <http://exclusions.oig.hhs.gov/search.html>

General Services Administration (GSA) database of excluded individuals/ entities: <http://sam.gov/>

Under the HITECH Act, if payments are made to an excluded / sanctioned provider, overpayment recovery must occur within 60 days of your being aware of the overpayment to mitigate potential False Claims Act (FCA) liability.

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 health care services.

By a Member	By a Provider
Lending an ID card to someone who is not entitled to it.	Billing for services, procedures and/or supplies that have not actually been rendered or provided
Altering the quantity or number of refills on a prescription	Providing services to patients that are not medically necessary
Making false statements to receive medical or pharmacy services	Balance-Billing a Medicaid member for Medicaid covered services
Using someone else's insurance card	Double billing or improper coding of medical claims
Including misleading information on or omitting information from an application for health care coverage or intentionally giving incorrect information to receive benefits	Intentional misrepresentation of manipulating the benefits payable for services, procedures and or supplies, dates on which services and/or treatments were rendered, medical record of service, condition treated or diagnosed, charges or reimbursement, identity of Provider/Practitioner or the recipient of services, "unbundling" of procedures, non-covered treatments to receive payment, "upcoding", and billing for services not provided
Pretending to be someone else to receive services	Concealing patients misuse of their ID Card
Falsifying claims	Failure to report a patient's forgery/alteration of a prescription

Reporting Suspected Fraud, Waste, & Abuse



- To report an issue by telephone, call Molina Healthcare's Compliance AlertLine (Hotline) toll free: 1-866-606-3889.
- To report an issue online,
 - visit: <https://molinahealthcare.AlertLine.com>
- You may also report an issue in writing. Please contact:

Molina Healthcare of Puerto Rico
Attn: Compliance
P.O. Box 364988
San Juan, PR 00936-4988

Coming Soon



Additional Resources

The MHPR Provider Manual
Prior Authorization Guides and Forms
Spanish Versions of Resource Documents and Forms

Additional Training

Service/Benefit Updates
Behavioral Health Services
Molina WebPortal

Questions and Answers



Your Extended Family