



Your Extended Family

# Texas Medicaid Medicare Program Provider Orientation

Molina Healthcare of Texas - Provider Services

# Agenda



- Provider Orientation Overview
- Molina Healthcare Overview
- Provider Online Resources
- Provider Manual, Online Directories and Web Portal Highlights
- Member Eligibility, Member ID and Enrollment Process
- Referrals and Prior Authorization, including Service Request Form
- Care Management/Model of Care
- Interdisciplinary Care Team
- Long Term Supports and Services
- Mental Health/Behavioral Health Services
- Medicare Comprehensive Health Evaluation/Annual Assessment
- Quality Improvement
- Access Standards
- Pharmacy
- Claims
- EFT
- Transportation Services
- Laboratory Services
- Disability, Literacy and Competency Training
- Cultural and Linguistic Expertise
- Balance Billing
- Fraud, Waste, & Abuse
- Frequently Used Phone Numbers



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## Purpose of Provider Orientation



The purpose of this provider orientation is to ensure that you as a provider have a good understanding of Molina Healthcare, our policies and procedures, and 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 Healthcare's provider network and look forward to our partnership to deliver quality, patient-centered, culturally sensitive, accessible and integrated healthcare services to our members.

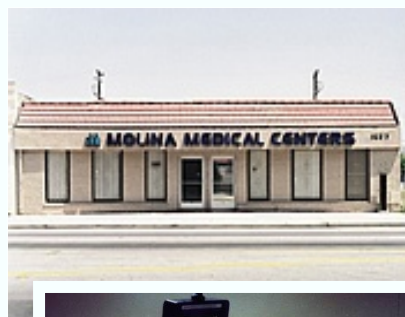


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# Our Story & Who We Are



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 30 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:*

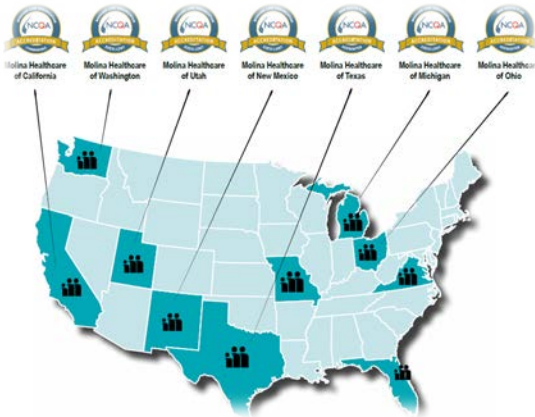
1. We care about the people we serve and advocate on their behalf
2. We provide quality service and remove barriers to health services
3. We are health care innovators and embrace change quickly
4. We respect each other and value ethical business practices
5. We are careful in the management of our financial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

***This is the Molina Way***

# Recognized for Quality, Innovation and Success

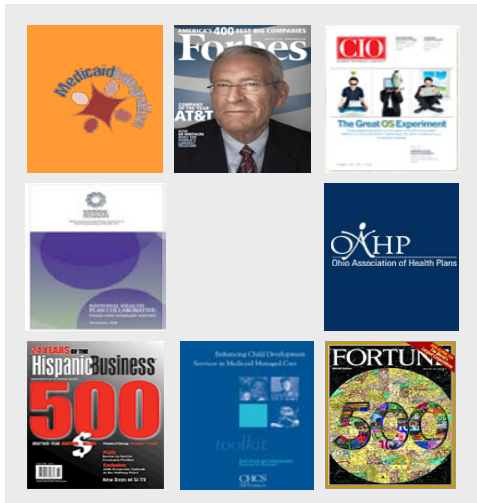


## Molina Healthcare Among the Nation's Best



### 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 2<sup>nd</sup> 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, recognized by Time Magazine as one of the 25 most influential Hispanics in America



# Upcoming Changes – Texas Demonstration to Integrate Care for Dual Eligible Beneficiaries



- The Texas Health and Human Services Commission in partnership with Centers for Medicare & Medicaid Services is launching a demonstration to promote coordinated high quality health care delivery to seniors and people with disabilities or individuals who are dually eligible for both Medicare and Medicaid (“dual eligible beneficiaries”) and help them stay in their homes for as long as possible.
- Services under the demonstration include, but are not limited to:
  - All Medicare services
  - All Medicaid services
  - Long-term support services, including in-home supportive services
  - Custodial care in nursing facilities, and
  - Mental health and substance abuse programs
- The initiative is called **The Medicaid Medicare Program (MMP)**.
- Enrollment will begin no sooner than March 2015.
- The Texas MMP removes fragmentation in care and promotes care coordination, improved beneficiary health and is cost-effective. Members will receive high quality care and enhanced benefits from one health plan, like Molina Healthcare of Illinois, that will be responsible for coordinating medical, behavioral and social and supportive service needs. Among other benefits, members will also have access to our nurse advise line and member services via telephone for assistance, 24 hours a day, 7 days a week, 365 days a year.

# Provider Online Resources



- 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](http://www.MolinaHealthcare.com)

[www.MolinaMedicare.com](http://www.MolinaMedicare.com)

[www.MolinaHealthcare.com](http://www.MolinaHealthcare.com) (DUALS WEBSITE)

**WELCOME CALIFORNIA PROVIDERS.**

**Provider Self Services**  
Login or Register

**SACRAMENTO COUNTY Low Income Health Program (LIHP)**  
Effective November 1, 2012

**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 and manage your patient's information
- View other information

**Provider Self Services**

User ID:   
 Password:   
[Accept & Login](#)  
[Forgot Password?](#)

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

Molina Healthcare · Bridge 2 Access

**MOLINA HEALTHCARE** | Your Extended Family.

Home Find a Pharmacy Find A Provider Find A Hospital

**Find A Provider**

Enter Your Location

Search by City or Zip Search By County Search Near Street Address

State: [Select] And City: [Select] Or Zip Code: [ ]

Coverage: [Select] Provider Type: [Select]

**More Search Options**

- Program
- Speciality
- Name, Language, Gender, Accept New Patients
- By Hospital
- By Medical Group

Show All Doctors

# Provider Manual and Highlights



MHT'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 printed copies of the Provider Manual by contacting your Provider Services Representative or view the manual on our provider website, at:

- Medicaid Program Provider Manual – [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com)
- **MMP Provider Manual** – [Insert Hyperlink for DUALS website](#)

Provider Manual Highlights	
▪ Benefits and Covered Services Overview	▪ Long Term Supports and Services
▪ Claims, Encounter Data and Compensation (including no member billing requirements)	▪ Member Grievances and Appeals
▪ Compliance and Fraud, Waste, and Abuse Program	▪ Member's Rights and Responsibilities
▪ Important Phone Numbers	▪ Model of Care
▪ Credentialing and Re-credentialing	▪ Pharmacy
▪ Delegation Oversight	▪ Preventive Health Guidelines
▪ Eligibility, Enrollment, and Disenrollment	▪ Provider Responsibilities
▪ Healthcare Services	▪ Quality Improvement
▪ Health Insurance Portability and Accountability Act (HIPAA)	▪ Transportation Services
▪ Interpreter Services	▪ Utilization Management, Referral and Authorization



# Provider Online Directory



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

To find a Medicaid provider, visit us at [www.molinahealthcare.com](http://www.molinahealthcare.com), and click Find a Provider or Find a Hospital or Find a Pharmacy.

To find a Medicare provider, visit us at [www.molinahealthcare.com](http://www.molinahealthcare.com)

To request a copy of our printed Provider Directory, call **(866) 449-6849** or contact your Provider Services representative.

The screenshot shows the Molina Healthcare website's 'Find a Provider' search interface. At the top left is the Molina Healthcare logo with the tagline 'Your Extended Family.' and the date 'Jan 08 2013 11:15:03 AM'. Navigation buttons include 'Home', 'Find a Pharmacy', 'Find A Provider', and 'Find A Hospital'. There are also links for 'Help', 'FAQ', and 'Español'. The main heading is 'Find A Provider' with a '\*Required' note. The search form is divided into three sections: 'Enter Your Location' with radio buttons for 'Search by City or Zip', 'Search By County', and 'Search Near Street Address', and dropdown menus for 'State\*', 'City\*', and 'Zip Code'; 'Select a Coverage & Provider Type' with dropdown menus for 'Coverage\*' and 'Provider Type\*'; and 'More Search Options' with expandable categories: 'Program', 'Specialty', 'Name, Language, Gender, Accept New Patients', 'By Hospital', and 'By Medical Group'. A 'Show All Options' link is at the bottom left. On the right side, there is a vertical banner with a photo of three healthcare providers and a 'Take a Tour' button.



MHT participating providers may register for access to our Web Portal for self service member eligibility, claims 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. Some of the services available on the Web Portal include:

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 PCP Member Roster	▪ Status check of authorization requests
▪ Submit online service/prior authorization requests	▪ Submit claims online

Self Service registration instructions and a complete training guide for the Web Portal are included in your Welcome Kit.

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



# 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

Provider Self Services

Jul 26 2012 11:05:25 AM  
Support User : NahayMis

Home MemberEligibility **Claims** Service Request/Authorization ProviderSearch New! EligibilityListing Download Account Tools Logout

## Newsletter

Newsletters

## Messages

No New Message

Medicare is available for Member Eligibility searches, Service Request/Authorization Submission, Service Request/Authorization Inquiry, Claim Submission and Claim status Inquiry. Please click [Contact Molina](#) to locate the Molina Medicare Member Services telephone numbers

## Recent Service Requests/Authorizations\*

[Show Recent Service Requests/Authorizations](#)

\* Displays the last 30 days' most recent Service Requests/Authorizations based on Submission Date

## Recent Claims \*

[Show Recent Claims](#)

\* Displays the last 30 days' most recent 5 Claims based on Date of Service

## Recent Claim files

You have no claim files in last 30 days.

[View more Claim files](#)

## Nurse Advice Reports

You have no Nurse Advice Reports in last 30 days.

[View more Nurse Advice Reports](#)

Member Eligibility Information (refer to next slide)

**Welcome**  
HDH PROFESSIONAL SERVICE CORP - 2504409

- Contact Molina
- View FAQs
- NPI Submission
- What's New Video!**
- Training Materials

**Forms**

- Service Request
- More Forms
- Prior Authorization cpt codes
- Prior Authorization drug classes when administered in a provider office
- Prior Authorization provider behavioral healthcodes
- LCD's and NCD's
- State Billing Guidelines

**Links**

- View Nurse Advice Reports
- HIPAA 5010
- Formulary
- Find a Pharmacy

**Survey**

**GIVE US YOUR FEEDBACK**

- Take the Web Portal Survey!
- Take the Provider Online Directory Survey

# 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 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)



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# Verifying Member Eligibility



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

*Please note - At no time should a member be denied services because his/her name does not appear on the eligibility roster. If a member does not appear on the eligibility roster please contact the Plan for further verification.*

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

**Medicaid Customer Service/IVR Automated System:** (866) 449-6849

**MMP/Texas Customer Service/IVR Automated System:** (866) 856-8699




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# Molina Healthcare Sample Member Identification (ID) Cards



## Molina Medicaid ID Card- Front

		<b>CFC</b>
Member <b>VINCENT TEST</b>		
Identification # <b>108123499099</b>	Date of Birth: <b>02/02/1962</b>	Effective Date: <b>07/01/2009</b>
Primary Care Provider: <b>LEROY B. TEST</b>		
Primary Care Provider Phone: <b>(937)223-1781</b>		
MMIS # <b>108123499099</b>	BIN # <b>610473</b>	Issue Date: <b>06/25/2009</b>

## Molina MMP ID Card- Front

Molina Medicare Options Plus (HMO SNP)	
Member:	
Member #:	
<hr/> PCP: <b>GARCIA, RAFAEL</b> PCP Phone: <b>(305)246-2221</b> Medical Copays: Office Visits: \$0 Specialist Visits: \$0 Urgent Care: \$0 ER Visits: \$0	
RxBIN:	
RXPCN:	
RxGrp:	
RxDID:	
	
Issue ID:	
Issued Date: <b>11/2/2010</b>	<b>H8130-001</b>

## Molina MMP ID Card- Front

## Molina Medicaid ID Card- Back

**MEMBERS:** To reach Member Services please call **(800) 642-4168** or for hearing impaired, call the TTY/Ohio Relay Service at **(800) 750-0750** or **(711)** Monday to Friday, 7 a.m. to 7 p.m.

To schedule transportation please call **(866) 642-9279**.

**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 to the emergency room, call your Primary Care Provider (PCP) at the number on the front of this card for instructions. You may also contact our 24-Hour Molina Healthcare Nurse Advice Line at **(888) 275-8750** or **(866) 648-3537 (Español)**. For hearing impaired, call TTY **(866) 735-2929**. Follow up with your PCP after all emergency room visits.

**PRACTITIONERS/PROVIDERS/HOSPITALS:** For prior authorization, post stabilization, eligibility, claim or benefit information call **(800) 642-4168**.  
Hospital Admissions: Authorization must be obtained by the hospital prior to all non-emergency admissions.

**PHARMACISTS:** For pharmacy questions, please call **(800) 642-4168**.

Claims Submission: P.O. Box 22712, Long Beach, CA 90801 - EDI Claims: WebMD-Payor #20149

[www.MolinaHealthcare.com](http://www.MolinaHealthcare.com)

## Molina MMP ID Card- Back

**Member Services:** 1-866-553-9494 or TTY at 1-800-346-4128  
Monday – Sunday, 8:00 AM to 8:00 PM local time  
24-Hour Nurse Advice Line: 1-888-275-8750  
24-Hour Nurse Advice Line TTY: 1-888-735-2929  
For Spanish Please Call: 1-866-648-3537.

**Providers/Hospitals:** For prior authorization, eligibility and general information, please call Member Services

**Submit Claims To:**  
Medical/Hospital:  
PO BOX 22811, Long Beach, CA 90801 please call Member Services (see above)  
Pharmacy:  
7050 Union Park Center, Suite 200, Midvale UT 84047  
please call Member Services (see above)

[www.molinamedicare.com](http://www.molinamedicare.com)

## Molina MMP ID Card- Back



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# PCP Assignment and Changes



**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 the following considerations:

- Proximity of the provider must be within 10 miles or 30 minutes of member's residence
- Member's last PCP, if known
- Member's age, gender and PCP needs
- Member's language preference
- Member's covered family members, in an effort to keep family together and maintain establish relationships

**PCP Changes** – Members may change their PCP at any time. All changes completed by the 25th of the month will be in effect on the first day of the following calendar month. Any changes on or after the 26th of the month will be in effect on the first day of the second calendar month

# PCP/Plan Initiated Disenrollment and Dismissals



**PCP Dismissals** - A PCP may find it necessary to dismiss a Member from his/her practice due to member non-compliance with recommended health care, or unruly and disorderly behavior.

- If the dismissal is inevitable, PCPs must immediately notify MHT's Member Services Department, attn: Member Services Director.
- These requests must include a detailed description of the circumstances prompting the Provider/Practitioner to initiate the request, including statement of the specific issue, dates of occurrence, and frequency of occurrence.
- Upon receipt of such request, the Member Services Director or designee will first make an effort to resolve the problem with the member through avenues such as PCP reassignment, education or referral services, and involvement of a Medical Case Manager RN to attempt to coordinate care.
- The member will be notified in writing of the intent to disenroll and given an opportunity to appeal.
- At no time should the Provider/Practitioner contact the member without approval of the Member Services Director or designee.

**Plan Initiated Disenrollment (PID)** - A Provider/Practitioner may request that a PID be processed for any of its members. However, MHT is responsible to initiate the process with HFS. Disenrollment can occur based on member:

- Permanently moving outside Molina's service area
- Committing Fraud and/or abusing membership card
- Losing Medicaid eligibility and/or entitlement to Medicare benefits



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# Referrals and Prior Authorization



Referrals are made when medically necessary services are beyond the scope of the PCPs practice. Most referrals to in-network specialists do not require an authorization from MHT. Information should 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 on the Molina Healthcare 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 your Welcome Kit, in our Provider Manual and also on our website at:

[www.MolinaHealthcare.com](http://www.MolinaHealthcare.com)

[www.MolinaMedicare.com](http://www.MolinaMedicare.com)



# 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
- MHT will process all “non-urgent” requests in no more than 14 business days of the initial request. “Urgent” requests will be processed within 72 hours of the initial request. If we require additional information we will pend the case and provide written communication to you and the Member on what we need. All referrals from Nursing Facilities and Hospitals will be managed as expedited requests.
- 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, MHT 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 Utilization Management Department using the Molina Healthcare Service Request Form, which is included in your Welcome Kit and available on our website, at:

Medicaid: [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com)

Medicare: [www.MolinaMedicare.com](http://www.MolinaMedicare.com)

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

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

Medicaid: Phone (866) 449-6849  
Fax (866) 420-3639

Medicare: Phone (866) 440-0012  
Fax (866) 420-3639

		Tracking#: _____ Please include Tracking number on claim. Expiration Date: _____	
Medi-Cal & HF Prior Authorizations: Phone: 800-526-5196 ext. 126400 Fax: 866-811-4804		Medicare Prior Authorization: Phone: 800-526-5196 ext. 129105 Fax: 866-472-0596	
<b>SERVICE REQUEST FORM</b>			
PRODUCT: <input type="checkbox"/> MEDI-CAL <input type="checkbox"/> HEALTHY FAMILIES <input type="checkbox"/> MEDICARE			
Service is: <input type="checkbox"/> NON-URGENT <input type="checkbox"/> URGENT ABUSE OF URGENT PA STATUS WILL BE MONITORED. Urgent request MUST be reserved for requests that are potentially life threatening or pose a significant risk to the continuous care of the patient. In the provider's best professional judgment, MHC reserves judgment of urgency and must meet definition above, therefore, please explain reason for urgency below.			
Member Name (Last, First, Middle Initial)		Date of Birth	Mem ID (Social Security Number)
Address (No., Street, City, State, Zip)		Phone Number: ( ) -	
<b>Referral/Service Type Requested</b>			
<input type="checkbox"/> Specialist Consult/Tx/FU Care <input type="checkbox"/> Inpatient Admission <input type="checkbox"/> Major Diagnostic Procedure <input type="checkbox"/> Home Health <input type="checkbox"/> DME (refer to PA list)		<input type="checkbox"/> Surgical Procedure <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Hospice <input type="checkbox"/> Comments:	
Requested LOS:		Requested Facility:	
Date/Time of Service:		Other: _____	
<b>Requesting Provider Information</b>		<b>Referring To Provider Information</b>	
Requesting provider name (last, first)		Referring to provider name (physician, mg/tpa, facility, agency)	
Address (No., Street, City, State, Zip)		Address (No., Street, City, State, Zip)	
Specialty		Specialty	
Phone Number ( ) -		Phone Number ( ) -	
Fax number ( ) -		Fax number ( ) -	
<b>Service Request Information</b>			
ICD-9 Code #/Description:		Code or Description:	
Clinical indications for request: (include pertinent past medical hx, treatment, physical findings, and attach all relevant medical records and test results, etc.)			
Requesting Practitioner Signature:		Date: / /	
<b>MOLINA Use Only</b>			
Criteria/guidelines met: <input type="checkbox"/> yes <input type="checkbox"/> no    Authorization Status: <input type="checkbox"/> approved <input type="checkbox"/> modified <input type="checkbox"/> deferred <input type="checkbox"/> denied			
Comments:			
UM representative signature:		Date:	Approved LOS:
<b>MEDICAL DIRECTOR REVIEW</b>			
<input type="checkbox"/> APPROVED <input type="checkbox"/> MODIFIED <input type="checkbox"/> DENIED		COMMENTS:	
MEDICAL DIRECTOR SIGNATURE:		Date: / /	
Confidentiality Notice: This fax transmission, including any attachments, contains confidential information that may be privileged. The information is intended only for the use of the individual(s) or entity to which it is addressed. If you are not the intended recipient, any disclosure, distribution or the taking of any action in reliance upon the fax transmission is prohibited and may be unlawful. If you have received this fax in error, please notify the sender immediately via telephone at the above phone number and destroy the original documents. Thank you.			
CLAIMS PAYMENT IS CONTINGENT ON MEMBER ELIGIBILITY FOR DATE(S) OF SERVICE			
			MOLINA FORM: 1451 REV: 08/17/2012



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# 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 Medicare and 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 supports 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 our Care Management Department at **(866) 409-0039** when you identify a Member who needs/might benefit from such services.

For additional Model of Care information, please visit our website at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com)

# Interdisciplinary Care Team (ICT)



Molina's ICT may include:

- Registered Nurse (RN)
- Social Worker
- Case Manager
- Utilization Management Staff
- Molina Medical Director
- Pharmacy
- Member's Primary Care Provider
- Member and/or Designee
- Care Transition Coach
- Service Providers
- Community Health Worker
- 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 Design



All members will have initial and annual health risk assessments and integrated care plans based on identified needs. Members are placed in the appropriate level of care management based on the assessment, their utilization history and current medical and psycho-social-functional needs. Molina's Care Management program consists of four programmatic levels as follows:

## **Level 1 – Health Management**

Health Management is focused on disease prevention and health promotion. It is provided for members whose lower acuity chronic conditions; behavior (e.g., smoking or missing preventive services) or unmet needs (e.g., transportation assistance or home services) put them at increased risk for future health problems and compromise independent living. The goal of Health Management is to achieve member wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation throughout the continuum of care.

At this level, members receive educational materials via mail about how to improve lifestyle factors that increase the risk of disease onset or exacerbation. Topics covered include smoking cessation, weight loss, nutrition, exercise, hypertension, hyperlipidemia, and cancer screenings, among others. Members are given the option, if they so choose, to engage in telephone-based health coaching with Health Management staff, which includes nurses, social workers, dieticians, and health educators.

## **Level 1: Health Management**

- Condition specific health education management
- Service coordination: transportation, scheduling appointments
- Community Resources
- Social, Behavioral, LTC Support
- Explanation of health plan benefits and services



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# Care Management Design



## Level 2 – Case Management

Case Management is provided for members who have medium-risk chronic illness requiring ongoing intervention. These services are designed to improve the member's health status and reduce the burden of disease through education and assistance with the coordination of care including LTSS. The goal of Case Management is to collaboratively assess the member's unique health needs, create individualized care plans with prioritized goals, and facilitate services that minimize barriers to care for optimal health outcomes.

Case Managers have direct telephonic access with members. In addition to the member, Care Management teams also include pharmacists, social workers and behavioral health professionals who are consulted regarding patient care plans. In addition to telephonic outreach to the member, the Care Manager may enlist the help of a Community Health Worker or Community Connector to meet with the member in the community for education, access or information exchange.

### Level 2: Case Management

- Multidisciplinary approach with assessment/care plans/member centered-goals
- Service coordination
- Medical, Social, Behavioral, LTC Support
- Condition specific education/management
- Explanation of health plan benefits and services



Your Extended Family

# Care Management Design



## Level 3 – Complex Case Management

Complex Case Management is provided for members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the health care system to facilitate the appropriate delivery of care and services.

The goal of Complex Case Management is to help members improve functional capacity and regain optimum health in an efficient and cost-effective manner. Comprehensive assessments of member conditions include the development of a case management plan with performance goals and identification of available benefits and resources. Case Managers monitor, follow-up and evaluate the effectiveness of the services provided on an ongoing basis. Complex Case Management employs both telephonic and face-to-face interventions.

Community Connector program will also be available for members receiving Level 3 & 4 – Complex Case Management. Community Connectors or “Promotoras” support Molina’s most vulnerable members within their home and community with social services access and coordination. Community Health Workers serve as patient navigators and promote health within their own communities by providing education, advocacy and social support.

### Level 3: Complex Case Management

- Multidisciplinary approach utilizing Interdisciplinary Care Team
- Utilize comprehensive and condition specific assessment(s)
- Member-centered prioritized goals
- Medical, Social, Behavioral, LTC Support
- Service coordination
- Incorporate home visits as appropriate
- Enlist Community Connector Focus on condition specific member education/self management skills
- Explanation of health plan benefits and services



Your Extended Family



# Care Management Design



## Level 4 – Imminent Risk

Level 4 focuses on members at imminent risk of an emergency department visit, an inpatient admission, or institutionalization, and offers additional high intensity, highly specialized services. Level 4 also includes those members who are currently institutionalized but qualify to transfer to a home or community setting. Populations most often served in Level 4 are the Dual-Eligibles (Medicare/Medicaid), those with severe and persistent mental illness (SPMI), those with Dementia, and the Developmentally Delayed. These services are designed to improve the member's health status and reduce the burden of disease through education as described in level 1.

These criteria include meeting an intensive skilled nursing (ISN) level of care, facing an imminent loss of current living arrangement, deterioration of mental or physical condition, having fragile or insufficient informal caregiver arrangements, having a terminal illness, and having multiple other high risk factors.

Comprehensive assessments of Level 4 conditions include assessing the member's unique health needs utilizing the comprehensive assessment tools, identify potential transition from facility and need for LTSS referral coordination, participate in ICT meetings, create individualized care plans with prioritized goals, and facilitate services that minimize barriers to care for optimal health outcomes.

### Level 4: Imminent Risk Case Management

- Multidisciplinary approach
- Utilize detailed assessment(s)
- Prioritized Goals
- Medical, Social, Behavioral, LTC Support
- Service coordination
- Incorporate home visits as appropriate
- Enlist Community Connector
- Focus on keeping the member in the least restrictive environment possible
- Focus on condition specific member education/self management
- Explanation of health plan benefits and services



Your Extended Family

# Care Management Design



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 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.



Your Extended Family

## Long Term Services and Supports (LTSS)



Molina MMP members have access to a variety of Long Term Services and Supports (LTSS) to help them meet daily needs for assistance and improve quality of life. LTSS benefits are provided over an extended period, mainly in member homes and communities, but also in facility-based settings such as nursing facilities as specified in his/her Individualized Care Plan. Overall, Molina's care team model promotes improved utilization of home and community-based services to avoid hospitalization and nursing facility care.



LTSS includes the following:

- Community Based Services
- In Home Supportive Services
- Skilled nursing facility services and
- Sub-acute care services
- Personal Assistant Service (PAS)
- Day Activity Health Service (DAHS)

Providers can submit referrals to Molina Healthcare for members to be assessed for PAS & DAHS services (new services or an increase in existing services) via fax (866) 420-3639.

The most effective way to request an assessment for a member is to have the member contact the Service Coordination department at (866) 409-0039 to request an initial or increase assessment.

# Mental Health/Behavioral Health Services



Mental and emotional well-being is essential to overall health. Sound mental health allows people to realize their full potential, live more independent lives, and make meaningful contributions to their communities. Reducing the stigma associated with behavioral health diagnoses is important to utilization of effective behavioral health treatment. Identifying and integrating behavioral health needs into care coordination, traditional health care, social services, person-focused care and community resources, is particularly important.

The following benefits are available to Molina MMP members and are a responsibility of the Health Plan:

- Mental health hospitalization
- Mental health outpatient services
- Psychotropic Drugs
- Mental health services within the scope of primary care physician
- Psychologists
- Psychiatrists

For Molina MMP members, rehabilitative mental health services, including crisis intervention, stabilization and residential, Molina works with and refers to county-administered behavioral health services to coordinate care for Molina members.

## How to refer Molina members in need of Mental Health/Behavioral Health services?

- Refer to Molina Prior Authorization requirements [insert link].
- Behavioral health participating providers should fax the Molina Healthcare Inpatient/PHP/IOP/Outpatient Behavioral Health Treatment Request form to Molina for outpatient treatment, to **(866) 617-4967**
- For both participating and non-participating providers, if the request is for inpatient behavioral health, Partial Hospitalization or an Intensive Outpatient Program for psychiatric and substance use disorders, the Molina Healthcare Inpatient/PHP/IOP/Outpatient Behavioral Health Treatment Request form should be faxed as soon as possible to the same number at **(866) 617-4967**
- If the admission to inpatient behavioral health is an emergency, prior authorization is not needed but the form should be faxed as soon as possible to **(866) 617-4967**
- The Molina Care Manager may call the behavioral health provider for additional clinical information, particularly if the Molina Healthcare Inpatient/PHP/IOP/Outpatient Behavioral Health Treatment Request form is not completely filled out.
- Interqual® medical necessity criteria is used to review the provided clinical information. The Molina psychiatrist may also contact the behavioral health provider for a peer-to-peer discussion of the member behavioral health needs.

## Crisis Prevention and Behavioral Health Emergencies

- Please contact our Nurse Advice Line available 24 hours a day, 7 days a week at (888) 275-8750 / TTY: (866) 735-2929

# Medicare Comprehensive Health Evaluation/Annual Assessment



All Molina Medicare and Medicare/Medicaid (Dual) members should receive a Comprehensive Annual Assessment from their PCP, at least once every year. As part of our Initial Health Risk Summary Program, Molina collects specific information about our members' health conditions from these assessments in order to improve coordination of care.

PCPs should ensure that all Molina Medicare members are assessed at least annually, and submit a completed Molina Medicare Health Evaluation Form to MHT and/or fax directly to (866) 420-3639. Please note the following:

- All chronic conditions should be adequately assessed and documented on your progress note (documentation such as monitoring, evaluation, assessment, and plan);
- Conditions for diagnosis codes submitted must be documented in your progress note; and
- Documentation and coding should be to the highest specificity possible.

We recognize that documenting this assessment creates additional work for PCPs and their staff, so we have developed a method of reimbursement to compensate providers for this service. For additional information contact your Provider Services Representative.

For risk adjustment, coding questions, and inquiries, please send an email to: Ramp@molinahealthcare.com

Molina Medicare Health Evaluation  
FAX COMPLETED FORM TO: 877-682-2216

Member Name: \_\_\_\_\_ PCP Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
HICR: \_\_\_\_\_ DATE OF SERVICE: \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_

PAST MEDICAL CONDITIONS (Diagnoses included here that are still active should also be assessed during this visit and included in the assessment section per CMS guidelines)

Condition	Condition

CURRENT MEDICATIONS: Please list current prescription and non-prescription medicines, vitamins, home remedies, herbs. Attach additional page if needed.  
 Medication reconciliation completed and reviewed with patient (discussed issues/questions)


ALLERGIES OR REACTIONS TO MEDICATIONS: \_\_\_\_\_

VITAL SIGNS (\*required):  
BP\* \_\_\_\_\_ Temp \_\_\_\_\_ Height\* \_\_\_\_\_ Weight\* \_\_\_\_\_ BMI\* \_\_\_\_\_ Pulse O<sub>2</sub> \_\_\_\_\_

REVIEW OF SYSTEMS

System	Negative	Positive
HEENT		Eye pain, ear pain, neck pain, visual problems, masses, hoarseness, other:
Respiratory		Cough, wheezing, sputum production, hemoptysis, other:
Cardiovascular		Chest pain, SOB, palpitation, orthopnea, other:
Gastrointestinal		Abdominal pain, nausea, vomiting, diarrhea, other:
Genitourinary		Difficult or painful urination, nocturia, frequency, hematuria, other:
Musculoskeletal		Joint pain, swelling, other:
Endocrine		Polyuria, heat or cold intolerance, other:
Neurological		Disoriented, Paresthesias, weakness, other:
Skin		Skin breakdown, rashes, pruritis, other:
Psychiatric		Fatigue, hallucinations, anxiety, depressed, other:

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## DIAGNOSIS CODES GUIDE 2013

This guide provides you with the most common diagnosis codes for chronic illnesses and/or disability in an outpatient setting. It also illustrates best practices for physicians and medical billing staff in regards to proper documentation and selection of codes for submission on CMS-1500 Claim forms. It is important to note that the codes listed are not all inclusive and should not be considered as a definitive list of conditions. The complete understanding of the components of a comprehensive chronic illness care plan is our mutual goal to help individuals maintain the highest possible quality of life.



Your Extended Family

# Quality Improvement



Quality is a Molina 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 and service quality is measured/evaluated/monitored through the following programs:

- Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Health Plan Survey (CAHPS®), CMS STARS 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
  - For more information on Molina Healthcare's Health Management Program, please call: Health Education **(877) 711-7455**.
  - Preventive Care and Clinical Practice Guidelines

For additional information about MHT's Quality Improvement initiatives, you can call **(877) 711-7455**, or visit our website: [click here](#)

# Access Standards



MHT monitors compliance and conducts ongoing evaluations regarding the availability and accessibility of services to Members. Please ensure adherence to these regulatory standards:

APPOINTMENT TYPE	WAIT TIME STANDARDS
Urgent Care	Within twenty-four (24) hours of the request
Office Wait Time	Should not exceed 30 minutes from appointment time
<b>Primary Care Provider (PCP) or Prenatal Care</b>	
Emergency Care	Immediately
Routine Care (non-urgent)	Within three (3) weeks of the request
Preventive Care	Within five (5) weeks of the request
Prenatal – First Trimester	Within two (2) weeks of request
Second Trimester	Within one (1) week of request
Third Trimester	Within three (3) days of request
Follow-Up Post Discharge	Within seven (7) days of discharge
<b>Specialty Care Provider (SCP)</b>	
Routine Care (non-urgent)	Within ten (10) working days of the request
<b>Mental/Behavioral Health</b>	
Non-Life Threatening Emergency Care	Within six (6) hours of request
Urgent Care	With twenty-four(24) hours of request
Routine Care	Within ten (10) working days of request

All physicians must have back-up coverage after hours or during absence/unavailability. MHT requires providers to maintain a 24 hour telephone service, 7 days a week. This access may be through an answering service or a recorded message after office hours. The after-hours telephone answering machine and/or answering service must instruct the member as follows: If this is a life threatening emergency, hang-up and call 911.

# Pharmacy/Drug Formulary



The Molina Drug Formulary was created to help manage the quality of our Members' pharmacy benefit. The Formulary 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 Formulary was created to ensure that Molina Healthcare of Texas members receive high quality, cost-effective, rational drug therapy. Molina Healthcare of Texas Drug Formularies are available on our website, at:

**Medicaid Formulary:** [click here](#)

**Medicare Formulary:** [click here](#)

Prescriptions for medications requiring prior approval, most injectable medications or for medications not included on the Molina Drug Formulary may be approved when medically necessary and when Formulary alternatives have demonstrated ineffectiveness. When these exceptional needs arise, providers may fax a completed Prior Authorization/Medication Exception Request.

**Medicaid Phone:** (855) 322-4080

**Prior Authorization Fax:** (888) 487-9251

**Medicare Phone:** (855) 322-4080

**Prior Authorization Fax:** (888) 487-9251

The Prior Authorization/Medication Exception Request is included in your Welcome Kit and available on our website

**Medicaid:** [click here](#)

**Medicare:** [click here](#)



Your Extended Family



# Claims Address



- **Medicaid Claims Submission Address “Fee-For-Service Claims”**  
Molina Healthcare of Texas  
P.O. Box 22719  
Long Beach, CA 90801
- **Medicare Claims Submission Address**  
Molina Medicare  
P.O. Box 22719  
Long Beach, CA 90801
- **EDI Claims Submission – Medicaid & Medicare**  
Edmeon Payor ID# 20554  
Emdeon Telephone (877) 469-3263

**Note: Online submission is also available through Web Portal Services at:**  
[www.molinahealthcare.com](http://www.molinahealthcare.com)



Your Extended Family

# Claims



**Claims Processing Standards:** On a monthly basis, 98% of Medicaid claims received by Molina from our health plans 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 State requirements and ensure providers are paid timely.

## ▪ **Claims Submission Options**

1. Submit claims directly to Molina Healthcare of Texas
2. Clearinghouse (Emdeon)
  - Emdeon is an outside vendor that is used by Molina Healthcare of Texas
  - When submitting EDI Claims (via a clearinghouse) to Molina Healthcare of Texas, please utilize the following payer ID # 20554.
  - EDI or Electronic Claims get processed faster than paper claims
  - Providers can use any clearinghouse of their choosing. Note that fees may apply

## ▪ **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](mailto:EDI.Claims@molinahealthcare.com)
- Contact your provider services representative

# Electronic Funds Transfer & Remittance Advice (EFT & ERA)



Molina Healthcare 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 Molina Healthcare.

## **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](mailto:Provider.Services@fisglobal.com)



# Transportation Services



Molina Healthcare of Texas provides non-emergent medical transportation for our members. Transportation can be scheduled on a recurring basis ahead of time.

If one of your patients is in need of this service, please have them **contact one of our Transportation Vendors or our Member Services Department** to see if they qualify.

*Note: It is important to have your patient(s) call three (3) days in advance of the appointment to schedule the transportation.*

## **Medicaid:**

**Logisticare - Dallas (855) 687-3255; TTD/TTY – (866) 288-3133**

**Medical Transportation Management – Houston (855) 687-4786**

**Medical Transportation Program – El Paso, Laredo, McAllen, San Antonio (877) 633-8747**

## **Medicare**

**Logisticare – (866) 475-5423 ; TTD/TTY – (866) 288-3133**

**Member Services – Medicaid : (866) 449-6849**

**Member Services – Medicare: (866) 856-8699**



# Laboratory Services



**Quest Laboratories** is the provider of laboratory services for Molina Healthcare of Texas members. Your patients will benefit from Quest Diagnostics comprehensive access, convenience, and choice with a broad array of services available locations throughout Texas.

Quest Laboratories offers:

- An extensive testing menu with access to more than 3,400 diagnostic tests so you have the right tool for even your most complicated clinical cases
- Approximately 900 PhDs and MDs are available for consultation at any time
- Results within 24 hours for more than 97% of the most commonly ordered tests
- 24/7 access to electronic lab orders, results, ePrescribing and Electronic Health Records
- Trained IT Specialists provide 24/7/365 support for all Quest Diagnostics IT solutions in your office, minimizing downtime and providing the answers you need quickly
- Less wait time at Patient Service Center locations with Appointment Scheduling by phone or online
- Email reminders either in English or Spanish about upcoming tests or exams

If you do not currently use Quest Diagnostics for outpatient laboratory services or have questions about Quest Diagnostics services, test menus, and patient locations, please call 866-MY-QUEST to request a consultation with a Quest Diagnostics Sales Representative.

# Disability, Literacy and Competency Training



## Chronic Conditions and Access to Services

Molina Medicare and Medicare/Medicaid (Duals) members 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 case management at (866) 409-0039**. This will also allow us to continue to expand access for this population to not only Primary Care Providers but also Long Term Support Services, Mental Health Providers, Community Supports and Medical Specialists. 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.

For additional information or questions on ADA, please contact our "Bridge2Access Connections" at (877) Molina7. Also, please refer to Molina Provider Education Series document – Americans with Disabilities Act (ADA) Questions & Answers for Healthcare Providers brochure.



# 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.

# Disability, Literacy and Competency Training



## 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 (access to Public Transportation and adequate parking), in to (including proper waiting room furniture and exam room equipment to meet the needs of all members), and through buildings including ensuring proper signage and way finding (e.g., color and symbol signage) are displayed throughout the facility.
- **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 provider's offices and equipment 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



Your Extended Family



# 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 dual eligible members and can also improve quality of life.

# Disability, Literacy and Competency Training



## Social Model vs. Medical Model of Disability

There is a fundamental difference between how people with disabilities are seen by society and how the disability community sees themselves.

Medical Model of Disability	Social Model of Disability
Disability is a deficiency or abnormality	Disability is only a difference
Being disabled is negative	Being disabled, in itself is neutral
Disability resides in the individual	Disability derives from interaction between the individual & society
The remedy for disability-related problems is a cure or normalization of the individual	The remedy for disability-related problems are a change in the interaction between the individual and society
The agent of the remedy is the professional	The agent of remedy can be the individual, an advocate or anyone who affects the arrangements between the individual and society

## Independent Living Philosophy

Developed by a group of students in Berkley, CA who were frustrated by the degree to which control over their lives had been taken over by medical and rehabilitation professionals. Their experiences gave birth to the philosophy that **“The freedom to make choices and the ability to live in the community is a basic civil right that should be extended to all people – regardless of disability”**. The students believed that they didn’t need to change to become integrated, but rather the environment and the attitudes toward persons with disabilities needed to change.

This is the philosophy of the Independent Living Centers (ILC’s), a network of nationwide consumer controlled, community based, cross disability, non-residential private nonprofit agencies with centers in Texas and across the United States. ILC staff work with consumers to promote independence in the community contrary to other agencies that may take on a *caretaker* or *protector* role. ILCs believe that the freedom to make choices, including mistakes, empowers people to further their involvement in their life and community.



For more information on the Independent Living Philosophy or other Disability issues, contact Molina’s “Bridge2Access Connections” at (877) Molina7.

# Disability, Literacy and Competency Training



## The Recovery Model

The mental health Recovery Model is a treatment concept wherein a service environment is designed such that individuals have primary control over decisions about their own care. This is in contrast to most traditional models of service delivery, in which individuals are instructed what to do, or simply have things done for them with minimal, if any, consultation for their opinions. The Recovery Model is based on the concepts of strengths and empowerment, saying that if individuals with mental illnesses have greater control and choice in their treatment, they will be able to take increased control and initiative in their lives. Providers should continue to provide members education about the possible outcomes that may result from various decisions and respect the value and worth of each individual as an equal and important member of society.

## Evidence Based Practices & Quality Outcomes

Evidence-based practice involves identifying, assessing, and implementing strategies that are supported by scientific research and maximizes three core principles: They are supported by the best research evidence available that links them to desired outcomes, they require clinical skill and expertise to select and apply a given practice appropriately, and they must be responsive to the individual desires and values of consumers, which includes consideration of individual problems, strengths, personality, sociocultural context and preferences.

Providers should strive for Quality Outcomes for each of their patients. Helping individuals achieve their highest level health and everyday function. Goals should be set for each patient and these goals should shape that patients treatment plan.

Quality Outcomes can be measured by using key factors such as:

- Patient's Satisfaction
- Level of Improvement concerning their condition or disease
- Functional Progress



Your Extended Family

# 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

**Questions? "Ask the Cultural and Linguistics Specialist" at:**

[http://molinahealthcare.com/medicaid/providers/ca/resource/ask\\_cultural.html](http://molinahealthcare.com/medicaid/providers/ca/resource/ask_cultural.html)

## Note – Interpretive Services

- MHT has interpreter services on a 24 hour basis. Please contact Member Services toll-free at: **(866) 856-8699**
- for more information.
- If you have a deaf or hard of hearing members, please contact us through our dedicated TTY line, toll-free, at **(800) 735-2989**
- MHT 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.

# Member Rights and Responsibilities



## Member Rights

- To be treated with respect and recognition of their dignity by everyone who works with MHC.
- To receive information about MHT, our providers, our doctors, our services and member's right's and responsibilities.
- To choose their primary care physician (PCP) from MHT's network.
- To be informed about their health. If members are ill, members have the right to be told about treatment options regardless of cost or benefit coverage. Members also have the right to ask for a second opinion about their health condition or to ask for an external independent review of experimental or investigational therapies.
- To have all questions about their health answered.
- To help make decisions about their health care. Members have the right to refuse medical treatment.
- To privacy. MHT keeps their medical records private in accordance with State and Federal laws.
- To see their medical record. Members also have the right to ask for corrections to their medical record and receive a copy of it in compliance with State/Federal requirements.
- To complain about MHT or their care by calling, faxing, e-mailing or writing to MHC's Member Services Department.
- To appeal MHT's decisions. Members have the right to have someone speak for them during the grievance.
- To disenroll from MHT.
- To decide in advance how they want to be cared for in case they have a life-threatening illness or injury.
- To receive interpreter services at no cost to help them talk with their doctor or MHT if they prefer to speak a language other than English.
- To not be asked to bring a friend or family member with them to act as their interpreter.
- To receive information about MHT, their providers, or their health in their preferred language.
- To request and receive materials in other formats such as larger size print and Braille.
- To request information in printed form translated into their preferred language.
- To receive a copy of MHT's drug formulary on request.
- To access minor consent services.
- To exercise these rights without negatively affecting how they are treated by MHT, its providers or the Department of Health Care Services.
- To make recommendations regarding the organization's member rights and responsibilities policies.
- To be free from controls or isolation used to pressure, punish or seek revenge.
- To file a grievance or complaint if they believe their linguistic needs were not met by the plan.
- To request a State Fair Hearing by calling **(xxx) xxx-xxxx**
- Members also have the right to receive information on the reason for which an expedited State Fair Hearing is possible.
- To receive family planning services, treatment for any sexually transmitted disease, emergency care services, from Federally Qualified Health Centers and/or Indian Health Services without receiving prior approval and authorization from MHT.

## Member Responsibilities

- Members have the responsibility to cooperate with their doctor and staff. This includes being on time for their visits or calling their doctor if they need to cancel or reschedule an appointment.
- Members have the responsibility to be familiar with and ask questions about their health benefits. If Members have a question about their benefits, they may call MHT's Member Services Department at **(866) 856-8966**.
- Members have the responsibility to provide information to their doctor or MHT that is needed to care for them.
- Members have the responsibility to be active in decisions about their health care.
- Members have the responsibility to follow the care plans and instructions for care that they have agreed on with their doctor(s).
- Members have the responsibility to build and keep a strong patient-doctor relationship.



Your Extended Family

# No Balance Billing



Providers may not balance bill the Member for any reason for covered services.

Your Provider Agreement with MHT requires that your office verify eligibility and obtain approval for those services that require prior authorization.

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

# Fraud, Waste, & Abuse



MHT 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” means 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)

“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)

# 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.

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.



# Deficit Reduction Act



On February 8, 2006, President Bush signed into law the Deficit Reduction Act (“DRA”). 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 Texas 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 Texas, 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 Texas will take steps to monitor Molina contracted providers to ensure compliance with the law.



Your Extended Family

# 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 been actually been rendered
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	Balancing 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 Molina Health card
Falsifying claims	Failure to report a patient's forgery/alteration of a prescription

- Provider can report suspected fraud, waste and abuse by calling our tip line at **(866) 606-3889**



# Frequently Used Phone Numbers



DEPARTMENT	NUMBER
Case Management	(866) 409-0039
Claims	(866) 856-8699
Claims Inquiry – Customer Service	(866) 856-8699
Community Outreach	(866) 449-6849
Fraud, Waste, and Abuse Tip Line	(866) 606-3889
Member Services – Medicare	(866) 856-8699
Member Services – Medicaid	(866) 449-6849
Molina’s “Bridge2Access Connections”	(877) Molina7
Pharmacy (Medicare/Duals)	(855) 322-4080
Prior Authorization (Inpatient)	(866) 449-6849
Prior Authorization (Outpatient)	(866) 449-6849
Provider Services	(866) 449-6849
Provider Services – Portal Help Desk	(866) 449-6848
Utilization Management	(866) 449-6849
24 Hour Nurse Advise Line	(888) 275-8750 / TTY: (866) 735-2929
Cultural and Linguistics Specialist: <a href="http://molinahealthcare.com/medicaid/providers/ca/resource/ask_cultural.html">http://molinahealthcare.com/medicaid/providers/ca/resource/ask_cultural.html</a>	

**Main (866)449-6849**

**TTY (800) 735-2989**

8:00am-5:00pm Monday-Friday



**Your Extended Family**

## Questions and Comments



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