

Molina Healthcare of Puerto Rico (MHPR) Non-Participating Provider Information

Please refer to Carta Normativa 15-0326 Re Transicion for details regarding the ASES-established Transition of Care and Reimbursement policies that MHPR will follow. An excerpt from the letter is pasted below:

RE: Special instructions for managing the transition, effective April 1, 2015

The Health Insurance Administration (ASES) provides the following instructions for the purpose of ensuring services and benefits for the continuity of health care for beneficiaries during the transition periods defined in the following scenarios, but not limited to such:

PHYSICAL AND MENTAL HEALTH SERVICES

Scenario 1: Insureds receiving basic coverage services

There will be a two (2) month transition period in effect from April 1, 2015 until May 31, 2015 for the following services provided by the current health entity:

- Services:
- Referrals or medical orders
 - Pre Authorizations (PA) such as: *High Tech*, *DME*, ambulances, and outpatient surgery, partial hospitalization, and electro-convulsive therapy, but not limited to such.
 - Transportation (Non-emergency service that is pre-authorized (PA) as an exception)

Instruction: 1. Health entities and their providers will honor all referrals and PAs that are in effect as of April 1, 2015 for a period of two (2) months. This means that any referral or PA that is in effect as of April 1, 2015, will be extended until May 31, 2015.

2. Health entities will honor transportation arrangements that patients have for this transition period.

Scenario 2: Insureds in a special coverage register: sickle cell anemia, rheumatoid arthritis, autism, cancer, chronic kidney disease, scleroderma, multiple sclerosis, lateral amyotrophic sclerosis, cystic fibrosis, hemophilia, leprosy, systemic lupus erythematosus, children with special conditions, tuberculosis, HIV-AIDS, and the obstetrics register.

A transition period of three (3) months will be applicable from April 1, 2015 to June 30, 2015 for the following services provided by the current health entity:

- Services:
- Referrals (if any) or medical orders
 - Pre-Authorizations (PA) such as *High Tech*, *DME*, ambulances and outpatient surgery, partial hospitalization, and electroconvulsive therapy, but not limited to such.
 - Transportation (Non-emergency service with pre-authorization (PA) by exception)
- Instruction:
1. Health entities and their providers will honor all the referrals, medical orders and PAs in effect as of April 1, 2015 for a period of three (3) months. This means that any referral or PA in effect as of April 1, 2015, will be extended until June 30, 2015.
 2. Health entities will honor transportation arrangements that patients have for this transition period.

We clarify that patients who are in the special coverage register have free access to specialists or subspecialists without the need of referrals.

Scenario 3: Patients registered in *Case Management* or in *Disease Management Programs*

A transition period of three (3) months will be applicable from April 1, 2015 until June 30, 2015 for the following services provided by the current health entity:

- Services:
- Referrals or medical orders
 - Pre-Authorizations (PA) such as *High Tech*, *DME*, ambulances and outpatient surgery, partial hospitalization, and electro-convulsive therapy, but not limited to such.
 - Transportation (Non-emergency service that is pre-authorized (PA) as an exception)
- Instruction:
1. Health entities and their providers will honor all referrals, medical orders and PAs in effect as of April 1, 2015 for a period of three (3) months. This means that any referral or PA in effect as of April 1, 2015, will be extended until June 30, 2015.

2. Health entities will honor transportation arrangements under a PA for this transition period.

Contact Information:

MHP Provider Services	Monday – Friday 7:00 AM – 7PM	1-888-558-5501
MHPR Member Services	Monday – Friday 7:00 AM – 7PM	1-877-335-3305
Molina Nurse Advice Line	7 Days/Week – 24 Hours/Day	1-888-620-1515

*Note - **We are also available from 7:00 a.m. to 5:00 p.m. on Saturday April 18th ***

- Please contact the Provider Services Center, 1-888-558-5501 for eligibility verification and questions.
- The MHPR Provider Directory can be located on our website

The screenshot shows the Molina Healthcare website interface for Puerto Rico. At the top, a light blue header bar contains the text "Showing Information For Puerto Rico" and two dropdown menus: "Puerto Rico" and "English". Below this is a white navigation bar with the Molina Healthcare logo on the left and the links "Find a Provider | Provider Portal" on the right. A red arrow points from the "Find a Provider" link to the "Showing Information For Puerto Rico" text. Below the navigation bar is a green menu bar with the following links: "Home", "Manual", "Forms", "Policies", "HIPAA", "EDI ERA/EFT", "Drug Formulary", and "Health Resources". The main content area features a large banner with a photograph of a smiling woman, Dr. Marina Jones, holding an X-ray. The text on the banner reads: "We're Glad you're part of the Molina Family". Below this is a quote: "I love working with Molina, their claim department is responsive and efficient" attributed to Dr. Marina Jones. At the bottom of the banner is a green bar with the text "Welcome Puerto Rico Providers!".

Claims

As a non-contracted provider, it is important to understand how the claims process works to avoid delays in processing your claims. The following items are covered in this section for your reference:

- Claim Submission
- Corrected Claim
- Claims Disputes/Adjustments
- Overpayments/Refund Requests
- Coordination of Benefits (COB)
- Third Party Liability (TPL)
- Billing the member

Claim Submission

Claims may be submitted to Molina Healthcare with appropriate documentation by mail or filed electronically (EDI) for CMS-1500 and UB-04 claims. For members assigned to a delegated medical group/IPA that processes its own claims, please verify the "Remit To" address on the member's Molina Healthcare ID card. Providers billing Molina Healthcare directly should send claims to:

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

Providers billing Molina Healthcare electronically should use current HIPAA compliant ANSI X12N format (e.g., 837I for institutional claims, and 837P for professional claims).

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 Commonwealth designated data requirements included in statutes or regulations
- 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 Commonwealth designated data requirements included in statutes or regulations.

National Provider Identifier (NPI)

Providers must report any changes in their NPI or subparts to Molina Healthcare within thirty (30) calendar days of the change.

Documents that do not meet the criteria described above may result in the claim being denied or returned to the provider. Claims must be submitted on the proper claim form, either a CMS-1500 or UB-04. Molina Healthcare will only process legible claims received on the proper claim form containing the essential data requirements. Incomplete, inaccurate, or untimely re-submissions may result in denial of the claim.

Electronic Claim Submissions and Claims Payment

Providers are encouraged to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow providers to reduce paperwork, provides searchable ERAs, and providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the provider for EFT enrollment, and providers are not required to be in-network to enroll. Molina Healthcare uses a vendor to facilitate the HIPPA compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at www.MolinaHealthcare.com/PuertoRico or by contacting our Provider Services Department.

Molina Healthcare offers the following electronic claims submission options:

- Submit claims directly to Molina Healthcare of Puerto Rico (MHPR) via the Provider Portal
- Submit claims to MHPR via your regular EDI clearinghouse using Payor ID 81794

Molina Healthcare of Puerto Rico uses Emdeon as its gateway clearinghouse. Emdeon has relationships with hundreds of other clearinghouses, including Inmediata and Assertus. Providers can continue to submit claims to their usual clearinghouse. Emdeon will receive those claims on behalf of Molina Healthcare.

Molina Healthcare of Puerto Rico accepts EDI transactions for claims via the 837P for Professional, and 837I for Institutional. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure claims are received for processing in a timely manner.

When your claims are filed electronically:

- You should receive an acknowledgement from your current clearinghouse
- You should receive a 999 acknowledgement from your clearinghouse within two (2) business days of your transmission

- You should contact your local clearinghouse representative if you experience any problems with your transmission

EDI Claims Submission Issues:

Providers who are experiencing EDI submission issues call the Molina Healthcare EDI Customer Service line at (866) 409-2935 or email us at EDI.Claims@molinahealthcare.com.

Timely Claim Filing

Provider 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 ninety (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 ninety (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.

Fraud and Abuse

Failure to report instances of suspected Fraud and Abuse is a violation of the law and subject to the penalties provided by law. Please refer to the Compliance section of this manual for more information.

Timely Claim Processing

Molina Healthcare will pay the provider of service within thirty (30) calendar days after receipt of clean claims.

The receipt date of a claim is the date Molina Healthcare receives either written or electronic notice of the claim.

Claim Review

Claims will be reviewed and paid in accordance with industry standard billing and payment rules, including, but not limited to, current Uniform Billing ("UB") manual and editor, Current Procedural Terminology ("CPT") and Healthcare Common Procedure Coding System ("HCPCS"), federal, state and commonwealth billing and payment rules, National Correct Coding Initiative ("NCCI") Edits, and Federal Drug Administration ("FDA") definitions and determinations of designated implantable devices and/or implantable orthopedic devices.

Non-contracted provider payments will be processed applying Molina Healthcare's proprietary allowable rates. Furthermore, provider acknowledges Molina Healthcare's right to conduct medical necessity reviews and apply clinical practices to determine appropriate payment. Payment may exclude certain items not billed in accordance with industry standard billing and payment rules or certain items which do not meet certain medical necessity criteria.

Claim Auditing

Provider acknowledges Molina Healthcare's right to conduct post-payment billing audits. Provider shall cooperate with Molina Healthcare's audits of claims and payments by providing access at reasonable times to requested claims information, all supporting medical records, provider's charging policies, and other related data. Molina Healthcare shall use established industry claims adjudication and/or clinical practices, state, commonwealth and federal guidelines, and/or Molina Healthcare's policies and data to determine the appropriateness of the billing, coding, and payment.

Coordination of Benefits and Third Party Liability

Medicaid is the payor of last resort. Private and governmental carriers must be billed prior to billing Molina Healthcare or medical groups/IPAs. Provider shall make reasonable inquiry of members to learn whether member has health insurance, benefits or Covered Services other than from Molina Healthcare or is entitled to payment by a third party under any other insurance or plan of any type, and provider shall immediately notify Molina Healthcare of said entitlement. In the event that coordination of benefits occurs, provider shall be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers and payers, not to exceed Molina Healthcare's proprietary allowable rate. The provider must include a copy of the other insurance's EOB with the claim.

Third Party Liability

Molina Healthcare is the payor of last resort and will make every effort to determine the appropriate Third Party payer for services rendered. Molina Healthcare 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.

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) calendar 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 Referral/Authorization form (if applicable) must accompany the adjustment request.
- The claim number clearly marked on all supporting documents

These requests shall be classified as a Claims Disputes/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: Claims Disputes / Adjustments
654 Plaza, Suite 1600
654 Avenida Munoz Rivera
San Juan, PR 00918

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.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of coverage decisions or payment levels, Molina Healthcare determines that it has made an overpayment to a provider for services rendered to a member, it will request recovery for such overpayment. Molina Healthcare will not reduce payment to that provider for other services unless the provider agrees to the reduction or fails to respond to Molina Healthcare's claim as required in this subsection.

A provider shall pay a claim for an overpayment made by a Molina Healthcare which the provider does not contest or deny within the specified number of days on the refund request letter mailed to the provider.

Payment of a claim for overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to the organization, or the date that the provider receives a payment from the organization that reduces or deducts the overpayment.

Billing the Member

Non-contracted providers may not bill the member for any covered benefit. Molina Healthcare places the responsibility for verifying eligibility and obtaining approval for those services that require prior authorization on the provider.