Provider Newsletter

For Molina Healthcare of Mississippi, Inc. providers

Third quarter 2025

In this issue

1 Benefits of submitting claims electronically
2 Update provider data accuracy and validation
3 National Plan and Provider Enumeration System review for data accuracy
4 Cultural competency resources for providers and office staff
6 Helping members in their language
7 Removal of OB authorization requirements
8 Important update regarding Prior Authorization submissions
9 Adherence to appointment time guidelines
11 Annual Model of Care Training requirement

The provider newsletter is available to all network providers serving Molina Healthcare of Mississippi, Inc. members.

Benefits of submitting claims electronically

Molina Healthcare, Inc. reminds our providers that submitting claims electronically through the **Availity Essentials portal** offers many advantages. These include:

- Improved Health Insurance Portability and Accountability Act (HIPAA) compliance
- Reduced operational costs associated with paper claims (printing, postage, etc.)
- Increased accuracy of data and efficient information delivery
- Fewer claim delays since errors can be corrected and resubmitted electronically
- Elimination of mail delays

How to submit electronic data interchange (EDI) claims:

A clearinghouse is the easiest way to submit EDI claims to Molina. You may submit EDI transactions through Molina's gateway clearinghouse, SSI Group, or use a clearinghouse of your choice, so long as that clearinghouse establishes a connection with SSI Group. Molina offers additional options for electronic claims submissions. If you do not have a clearinghouse, log in to the **Availity portal** for more information.

Update provider data accuracy and validation

Providers must ensure Molina has accurate practice and business information. Accurate information allows us to better support and serve our members and providers.

Molina must maintain an accurate and current Provider Directory. It is a state and federal regulatory requirement and a National Committee for Quality Assurance (NCQA) requirement. Invalid information can negatively impact members' access to care, member/primary care provider (PCP) assignments and referrals. Additionally, current information is critical for timely and accurate claims processing. Providers must validate their information on file with Molina at least once every ninety (90) days for correctness and completeness.

Failure to do so may result in your REMOVAL from the Molina Provider Directory.

Provider information that must be validated includes, but is not limited to:

- Provider or practice name
- Location(s)/address(es)
- Specialty(ies)
- Phone, fax numbers and email
- Digital contact information
- Whether your practice is open to new patients (PCPs only)
- Tax ID and/or National Provider Identifier (NPI)

Delegated and other providers that typically submit rosters must submit a complete roster that includes the above information to Molina.

All other providers must log into their Council for Affordable Quality Healthcare (CAQH) account to attest to the accuracy of the above information for each health care provider and/or facility in your practice contracted with Molina.

If the information is correct, please select the option to attest. If it is incorrect, providers can make updates through the CAQH portal. Providers unable to make updates through the CAQH portal should contact their Provider Services representative for assistance.

Additionally, per the terms specified in your Provider Agreement, providers must notify Molina of any changes, as soon as possible, but at least thirty (30) calendar days in advance, of any changes in any provider information on file with Molina. Changes include, but are not limited to:

- Change in office location(s)/address, office hours, phone, fax or email
- Addition or closure of office location(s)
- Addition of a provider (within an existing clinic/practice)
- Change in provider or practice name, Tax ID and/or NPI
- Opening or closing your practice to new patients (PCPs only)
- Change in specialty(ies)
- Change in any other information that may impact members' access to care

National Plan and Provider Enumeration System review for data accuracy

Your NPI data in the National Plan and Provider Enumeration System (NPPES) must be reviewed to ensure accurate provider data. Providers are legally required to keep their NPPES data current.

When reviewing your provider data in NPPES, please update any inaccurate information in modifiable fields, including provider name, mailing address, phone and fax numbers and specialty. You should also include all addresses where you practice and actively see patients and where a patient can call and make an appointment. Do not include addresses where you do not actively practice. Please remove any practice locations that are no longer in use. Once you update your information, you must confirm it is accurate by certifying it in NPPES. Remember, NPPES has no bearing on billing Medicare fee-for-service.

If you have any questions about NPPES, visit **NPPES.CMS.HHS.gov**.

Cultural competency resources for providers and office staff

Let's partner to achieve health equity! Training modules and resources on cultural competency are available to review when communicating with and serving diverse patient populations. This information helps you and your staff understand and address disparities to improve health care and outcomes. As our provider partner, assisting you is one of our highest priorities. We look forward to supporting your efforts so all our members have the same opportunity to attain their highest level of health.

We are committed to improving health equity as a culturally competent organization. We support and adhere to the **National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care** established by the Office of Minority Health. We also comply with regulatory and accreditation standards focused on health equity.

Building culturally competent health care: Resources for providers and staff

Cultural competency can positively impact a patient's health care experiences and outcomes. Cultural competency training modules and resources are available to providers and office staff. You can access the resources through **Availity**.

Cultural competency educational resources include:

- Cultural competency, including culturally and linguistically appropriate services (CLAS)
- Language access services, including effective communication strategies
- Health equity and disparities
- Social determinants of health
- Federal requirements, including the Affordable Care Act and the Americans with Disabilities Act

These resources also provide helpful tips and recommendations for effectively supporting unique subpopulations and communities, including racially, ethnically, culturally and linguistically diverse communities, LGBTQIA+ individuals, older adults, people with disabilities and immigrants/refugees.

The training modules last 5 to 10 minutes. Depending on the topic of interest, you may participate in all or just one module. Upon completing the training, please submit the provider attestation form available through **Availity**. Please contact your provider services representative if you have any questions.

Americans with Disabilities Act (ADA) resources: Provider education series

A series of provider education materials related to disabilities is also available to providers and office staff on Molina's website. To review the materials, please log in to **Availity**.

Cultural competency resources for providers and office staff (continued)

Disability educational resources include:

- Overview of the Americans with Disabilities Act (ADA), including frequently asked questions for health care providers
- Information for members who are blind or have low vision, including how to request alternate formats
- Guidance on service animals and related accommodations
- Tips for communicating with people with disabilities and older adults

Please contact your provider services representative if you have any questions.

Molina's language access services

Language access services ensure mutual understanding of illness and treatment, increase patient satisfaction and improve health care quality for patients who speak a language other than English. Molina ensures effective communication with members by providing language access services. Providing language access services is a legal requirement for health care systems that receive federal funds. A member cannot be refused services due to language needs. Molina provides the following services directly to members at no cost, when needed:

- Written materials in other formats, such as large print, audio, accessible electronic formats and braille
- Written materials translated into languages other than English
- Interpreter services, including American Sign Language
- Relay service (TTY: 711)
- 24-hour Nurse Advice Line
- Bilingual staff

In many cases, Molina will also cover the cost of an interpreter for our members' medical appointments. Molina members and providers are instructed to call Member and Provider Services to schedule interpreter services or to connect to a telephonic interpreter.

Molina's materials are always written simply in plain language and at required reading levels.

You can access resources and materials on cultural competency, disability-related services and language access services by logging in to Availity or visiting the Molina website. If using **Availity**, you must first log in and navigate to Molina Healthcare under **Payer Spaces**, then select the **Resources** tab to view the available resources. If using the **Molina website**, navigate to the **Health Care Professionals** site. Under the **Health Resources** tab, select the **Culturally and Linguistically Appropriate Resources/Disability Resources** page to view the available resources.

For additional information on Molina's language access services or cultural competency resources, contact your provider services representative or visit **MolinaHealthcare.com**.

Helping members in their language

Our health plan members speak many different languages.

As of late 2024, for Medicaid members, the majority of language translation requests were for Spanish, accounting for 82% of the total. This was followed by 3% for Arabic, 2% each for Russian, and Chinese dialects, and 1% each for Vietnamese, Dari, Haitian Creole, Ukrainian, French, and Swahili.

Please contact Molina if you need assistance addressing the language needs of your patients. We also provide resources for providers.

Provider Manuals

Provider Manuals are customarily updated annually but may be updated more frequently as needed. Providers can access the Provider Manual at **MolinaHealthcare.com**.

Clinical policies

Molina's clinical policies (MCPs) are located at **MolinaClinicalPolicy.com**. Providers, medical directors and internal reviewers use these policies to determine medical necessity. The Molina Clinical Policy Committee (MCPC) reviews MCPs annually and approves them bimonthly.

Removal of OB authorization requirements (MSCAN/CHIP only)

Molina Healthcare of Mississippi continues to strive to better serve our members and work efficiently with providers. Effective May 1, 2021, no prior authorization (PA) is needed to be on file for claims submission for routine deliveries that are not complicated and do not exceed the routine timeframes (three days for vaginal or five days for C-Section) for the claim to pay.

Molina will continue to require authorizations to determine medical necessity on OB delivery stays that are non-routine or complicated.

Providers should wait to file a claim for the below stays until receiving a determination letter.

- Scheduled deliveries before 39 weeks gestation need PA. PA should be obtained prior to admit. Urgent PAs are due within 24 hours, and standard PAs are up to 3 days.
- Delivery stays that are non-routine or complicated (e.g. O10-O16, O20-O29, O30-O48, O60-O77, O85-O92, O94 -O9A, O09, O00-O08)
- Delivery in-house stays that exceed routine time frames (notification to be filed no later than day 4 for vaginal/ day 6 for C-Section)
- Sick newborns (Sick baby revenue codes that required a PA regardless of the length of stay, (e.g. 172, 173, 174)
- Newborns who require services other than normal newborn care (e.g., stay beyond 5 days or stays after the moms discharged)

Note: The Division of Medicaid (DOM) will continue to require providers to submit newborn enrollment forms. Molina will continue to generate an authorization from the form.

Important update regarding Prior Authorization submissions

Coming Soon

Molina will begin requiring additional documentation—including clinical records—for all prior authorization submissions*. The clinical records submitted should be for the prior authorization being requested. Attachments will function as required fields. Without them, the system will block the submission.

This update is designed to:

- Streamline the review process
- Minimize back-and-forth communication with our Utilization Management team
- Enable faster, more informed decision-making

Action Required:

- Begin attaching clinical supporting documentation when requesting a Prior Authorization. The clinical records submitted should be for the prior authorization being requested.

We appreciate your support in helping us improve efficiency and service quality.

Availity training available

Want to explore all the Availity features? Access our on-demand training anytime at Molina PA Training.

Before accessing the training, be sure that **you're logged in to Availity**.

Your browser allows pop-ups from the following sites:

- **Apps.availity.com**
- **Availity.com**
- **Learnupon.com**

Register today:

If your organization is not currently registered for Availity Essentials, the person in your organization designated as the Availity administrator should go to **Availity.com** and select Get Started. If you need assistance registering with Availity Essentials, visit Availity Customer Support.

Thank you for your participation in our network.

*If the Molina provider agreement specifically states that medical records do not need to be submitted for prior authorization approval or if state law or a government contract prohibits such medical records from being required for Medicaid or Marketplace, then this communication does not apply.

Adherence to appointment time guidelines

As part of our commitment to timely, quality care, Molina Healthcare maintains access to care standards and conducts ongoing monitoring of access to health care services delivered by our contracted providers.

This includes regular reviews and surveys of:

- **Primary Care Providers (PCPs):** Family/General Practice, Internal Medicine, and Pediatrics
- **High-Volume Specialists:** OB/GYN
- **High-Impact Specialists:** Oncology
- **Behavioral Health Providers**

All participating providers are **required to meet the access to care appointment standards** outlined below to ensure members receive health care services in a timely manner.

Regular monitoring ensures compliance with these standards and supports our shared goal of providing accessible, high-quality care.

Appointment access

All Providers who oversee the Member's health care are responsible for providing the following appointments to Molina Members in the timeframes noted.

Medical appointment

Appointment type	Standard
Routine, asymptomatic	Within 30 calendar days
Routine, symptomatic	Within 7 calendar days
Urgent Care	Within 24 hours
After Hours Care	24 hours/day; 7 days/week availability
Specialty Care (High Volume)	Within 45 calendar days
Specialty Care (High Impact)	Within 45 calendar days
Urgent Specialty Care	Within 24 hours

Adherence to appointment time guidelines (continued)

Behavioral health appointment

Appointment type	Standard
Life Threatening Emergency	Immediately
Non-life-Threatening Emergency	Within 6 hours
Urgent Care	Within 48 hours
After Hours Care	24 hours/day; 7 days/week availability
Initial Routine Care Visit	Within 10 business days
Follow-up Routine Care Visit	Within 7 calendar days*

Thank you for your continued commitment to our members and for partnering with us in meeting these critical standards.

Annual Model of Care Training requirement

Molina Healthcare of Mississippi is required to provide annual training regarding our Model of Care program for SNP enrollees. The Model of Care is the foundation for Molina's care management policy, procedures, and operational systems for our SNP population.

To ensure that Molina remains compliant with Centers for Medicare and Medicaid (CMS) regulatory requirements for Model of Care training, receipt of a completed Attestation Form is due to Molina no later than **12/31/2025**.

What you need to do

1. Take the Model of Care Training

   The written training materials on the Molina Healthcare Model of Care can be found on the Molina website at: Molina Medicare Model of Care

2. Complete and sign the Model of Care Training Attestation form Moc MS

   Note: If one Attestation form is being returned for a group or clinic, it must be signed by an individual with the authority to sign on behalf of the group/clinic and an attendance roster indicating which providers completed the training must be attached.

   A copy of the Model of Care Training Attestation form is available via a link at the end of the Model of Care Training Deck, or it is available on the **MolinaHealthcare.com** Medicare provider webpage.

3. Return Attestation Form to Molina Healthcare via the automated submit button on the form, or via email at **MHMSProviderServicecs@MolinaHealthcare.com**

   Please contact your Provider Services Representative.

Thank you for your immediate response and cooperation.