



Medical Record Keeping Tips

Did you know ... a confidential medical record, including all pertinent information on medical services rendered, must be maintained for each of your patients? A recent audit of the medical record keeping practices of Molina providers was conducted, focusing on six categories that have been designated as critical areas of importance. The compliance results are summarized below.

<i>Critical Areas</i>	<i>Compliance Rate</i>
Problem Lists	60.00%
Allergy designation	90.00%
Past medical history	93.33%
Working diagnosis consistent with findings	96.67%
Plans of action/treatment consistent with diagnosis	100.00%
Medically appropriate care	100.00%

Please follow all medical record keeping standards and remember that Problem Lists must be included in every medical record. For a detailed explanation of medical record standards, refer to your Provider Manual or go to the Provider Responsibilities section of Molina's website at www.MolinaHealthcare.com.

Claims Chat: Credit Balances (Advances)

- ◆ A credit balance occurs when the amount of money being deducted as a result of claim payment reversal(s) is greater than the total payment of the claims on the current remittance advice. Once a credit balance is created, it will be applied to the payments on future remittances until the balance reaches zero.
- ◆ Credit balances will only be applied to the same line of business as the original reversed claim(s) (Aged, Blind or Disabled, Healthy Start/Healthy Families). As a result, a credit balance may carry over even though a current remittance advice payment exceeds the credit balance. This happens when there are payments for an unrelated line of business.
- ◆ The credit balance amount may not match the amount for one specific claim. There may be multiple claims on the remittance advice that total the amount of the credit balance applied.
- ◆ The credit balance will not be applied to claims for the same member. Once a credit balance is created it becomes a net dollar amount that is applied to future remittance payments, not to claims for specific members.

Claims Chat, cont.

- ◆ For providers with multiple payment addresses, the advances will be applied to payments made to the same pay-to provider.
- ◆ To correctly post advance amounts, it is important to keep any remittance advices where a credit balance was created. You will need to reference the reversed claims on these remittance advices to accurately post future payments until the credit balance has been applied.
- ◆ Please keep any overpayment letters for future reference when posting credit balances.

**Billing for E&M and Preventive Services
On the Same Date of Service**

Did you know that Molina will pay for both a new/established patient E&M and new/established patient preventative visit for the same member on the same date of service if the diagnosis codes billed support payment of both codes? Be sure to bill the correct diagnosis codes and bill the new/established patient E&M with modifier 25 to ensure accurate payment.

Good Form!

Molina's Website, www.MolinaHealthcare.com, is the best resource for all the forms you need. One essential form is the **Provider Information Update Form**. Use this form when you:

- add a new physician to your group,
- make demographic changes,
- need to notify Molina of a physician leaving your practice, or
- change your Tax ID.

Molina's Provider Services Representatives can answer any questions that you have about our forms. They are available at 1-800-642-4168 Monday through Friday, 8:00 a.m. to 5:00 p.m..

It Matters to Molina ... Really!

Be on the alert for a visit from your Molina External Provider Services Representative! Our representatives are on a mission to deliver the new "It Matters to Molina" postcards to your office. We value your opinions and want you to share your comments, concerns, ideas, and feedback with us. Please take a moment to fill out the postage-paid card and drop it in the mail.

New ePortal Enhancements for Molina Providers:

Member Eligibility Improvements

- ◆ The new Member Eligibility and Benefits page includes:
 - Medicare and Medicaid eligibility
 - Eligibility history, including benefit plans and PCPs
 - Enrollment restrictions
 - Coordination of Benefits (COB) information
- ◆ New search options make it easier to narrow your search.
- ◆ Family Search gives you new options to find infants and other family members using the mother's, father's or sibling's information.

Multiple Provider Accounts

- ◆ ePortal Account Administrators can add multiple providers with different Provider and Tax ID's to a single ePortal account from the "Manage Providers" link.
- ◆ Switching between providers under one ePortal account is easily managed by a drop-down menu located on the homepage.

Entitlement Reviews

- ◆ Account Administrators will now be required to perform reviews every six months to confirm that their office's user status remains accurate.
- ◆ Reminders will be sent to both account administrators and office users when the Entitlement Review deadline nears.

Office User - Role-Based Access

- ◆ ePortal administrators can assign specific user roles to each office user from the "Manage Office Users" link.

Revised User Lock-Out Policy

- ◆ Accounts not accessed for more than sixty (60) consecutive days will no longer be automatically locked out of ePortal. Instead, users will be asked to change their password and then allowed to log in to the ePortal.
- ◆ User accounts will now be locked after three (3) unsuccessful password attempts.
- ◆ Account Administrators can unlock their own accounts by completing the secret security questions chosen during the first login. This feature is only available to administrators.
- ◆ Office users will be directed to contact their account administrator to unlock their account.

Protected Health Information (PHI) Security Measures

- ◆ All downloadable reports now contain the user ID in the footer of each page. Also, the user ID is visible on all ePortal screens and will remain visible if printed.
- ◆ The Molina Provider ID on ePortal screens will be masked - only the last four (4) digits are identified.
- ◆ All emails sent out of ePortal are now marked secure.
- ◆ Only IP addresses located within the United States are allowed to access the ePortal website.

New Requirement When Submitting a Professional Claim

- ◆ To submit a professional Claim, the Provider must now enter a Diagnosis Code Reference value of 1 through 4 for each procedure performed that relates to the primary diagnosis. Please note this is now a required field in accordance with HIPAA guidelines.

Reminder: Molina Healthcare Partners with HealthCare Insight

Effective November 1, 2006, Molina Healthcare of Ohio, Inc. began instituting editing services with the help of our strategic business partner HealthCare Insight (HCI). This service protects our clients from the unnecessary expenditures that result from inaccurate or inappropriate coding of claims and creates more accurate and equitable reimbursement for all billing providers.

This partnership ensures that more exacting programs are in place to ensure that only accurately and properly coded and billed services are reimbursed.

- ◆ Services that are restricted by age or gender are only be paid as appropriate.
- ◆ Global surgical packages that include uncomplicated follow-up visits are more accurately tracked and related post-operative visits denied.
- ◆ Billing for services that are not reimbursable, and billing fees for assistant surgeons and secondary surgical procedures, are more accurately identified and payments reduced in accordance with coding and reimbursement guidelines.

These are just some of the more comprehensive applications of coding and reimbursement rules that are now possible because of improved technology and our implementation of clinical review. The coding and billing rules that Molina Healthcare has applied are industry standards as published and defined in CPT and by CMS and are the same policies that providers will encounter from most other health care payors. Determinations for non-payment or reduced payments are based upon CPT coding and reimbursement protocols and guidelines, and **do not** represent opportunities for providers to balance bill patients.

HCI provides skilled clinical and coding analysts in addition to software editing to assess and evaluate the coding of claims. This is in addition to all other reimbursement processes that Molina Healthcare employs. By utilizing RNs to review system-detected reimbursement issues, HCI is able to evaluate the claim from a clinician's perspective, and in doing so, their nurses will authorize payment on many services that the system would normally deny. This prevents unnecessary resubmissions of claims and provides more consistent and logical claims processing.

Molina Healthcare has a responsibility to control health care costs for our clients and for all patients. These improvements to our claims adjudication processes enable us to more effectively and universally implement fair reimbursement rules and guidelines aimed at providing equitable reimbursement to all providers.

New Address to Send Refunds

In an effort to improve turnaround time for refund processing, Molina Healthcare of Ohio, Inc. has set up a lockbox for you to submit all refund checks. The address is listed below.

Molina Healthcare of Ohio, Inc.- 715257
P.O. Box 715257
Columbus, Ohio 43271-5257

Claims Reconsideration vs Corrected Claim: What is the Difference?

Claims Reconsideration: This is any request submitted to MHO to reconsider a payment in question or a denied claim. A completed Claims Reconsideration Form should be completed and faxed to (614) 781-4464 along with all documentation supporting the request.

Corrected Claim: This is any addition or deletion to a claim already submitted and processed. A Corrected Claim – Standard Cover Sheet should be completed and submitted to the address below:

**Molina Healthcare, Inc.
P O Box 22712
Long Beach, CA 90801**

Both of these forms can be found on our website www.MolinaHealthcare.com under “Forms.”

HEDIS[®] Medical Record Abstraction: FULL SPEED AHEAD

It's that time of year! Healthcare Effectiveness Data and Information Set (HEDIS) data collection is now in full-swing. Practices like yours are being contacted by a variety of Managed Care Organizations, 3rd Party Payors, and Vendors in order to obtain data to report performance on quality of care and service.

As in years past, Molina Healthcare of Ohio, Inc. (MHO) has contracted with MedAssurant to perform the majority of HEDIS medical record data abstractions on our behalf. If MedAssurant contacts your office to schedule data collection or to arrange for records to be faxed and mailed, you can be confident that MedAssurant will treat your patients' PHI with total protection and confidentiality. As defined by the Health Insurance Portability and Accountability Act (HIPAA), MedAssurant is serving as a “business associate” of “covered entities” and, therefore, is legally bound to protect, preserve and maintain the confidentiality of any PHI obtained pursuant to its contractual obligations to MHO.

We appreciate your continued work to improve the health of our members and know that your efforts will be reflected in our HEDIS results. Thank you for extending professional courtesy to MedAssurant and to the MHO Quality staff as we work together to complete this important project.

Should you have any questions please contact Barbara Marshall, HEDIS Program Manager, at 1-800-357-0146; ext. 214483.

Molina Offers Continuing Medical Education on the Web

Molina Healthcare's goal is to deliver excellent service to all we serve -- including our providers. In order to reach this goal, Molina Healthcare has created three Continuing Medical Education (CME) courses, accredited for CME credit (AAFP Prescribed credits approved.). To find this information, go to www.MolinaHealthcare.com and click on "Health Resources."



MOLINA HEALTHCARE of Ohio
DRUG FORMULARY UPDATE
March, 2009

The status of the following medications has changed on the 2009 Molina Healthcare of Ohio Drug Formulary:

Drug Name TRADE (Generic)	Therapeutic Category	Formulary Status	Effective Date	Formulary Page No.
Nasonex Nasal Spray	steroid	Non-formulary	April 1st	

PRIOR AUTHORIZATION CRITERIA. The following criteria are either new or revised. Prior authorization criteria for Formulary medications are found at the back of the 2008 Drug Formulary and on the Molina Healthcare website.

DRUG NAME TRADE (generic)	Prior Authorization Criteria (abbreviated)
Nasonex (mometasone)	Use generic fluticasone, flunisolide
Kapidex (dexlansoprazole)	Use Prilosec OTC 20mg up to 40mg
Banzel (rufinamide)	For seizures of Lennox-Gastaut Syndrome only

An interactive version of the formulary is also available for pda download at www.epocrates.com.