



Provider Availability

A Contracted Primary Care Provider must ensure that he/she will be available or accessible, or arrange to have another qualified medical professional available or accessible twenty four (24) hours a day, seven (7) days a week.

The following are acceptable and unacceptable telephone arrangements for contracted PCPs after their normal business hours:

Acceptable after-hours coverage

The office telephone is answered after-hours by an answering service, which meets language requirements of the Major Population Groups served and which can contact the PCP or another designated medical practitioner.

- All calls answered by an answering service must be returned within 30 minutes;
- The office telephone is answered after normal business hours by a recording in the language of each of the
- Major Population Groups served, directing the patient to call another number to reach the PCP or another provider designated by the PCP.
- Someone must be available to answer the designated provider's telephone. Another recording is not acceptable; and
- The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical practitioner, who can return the call within 30 minutes.

Unacceptable after-hours coverage

- The office telephone is only answered during office hours;
- The office telephone is answered after-hours by a recording that tells patients to leave a message;
- The office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed; and
- Returning after-hours calls outside of 30 minutes.

In This Issue

Provider Availability	pg 1
Influenza and Pregnancy	pg 2
HIPAA 5010	pg 3
Access to Care	pg 4
Utilization Management	pg 4
HEDIS and CAHPS Results	pg 5
Nurse Advice Line	pg 5
ICD-10 CM and PCS	pg 6

Medicare Section pg 7

Special Needs Population	pg 7
Affordable Care Act	pg 8
Concern for Older Patients	pg 9
Coordination of Care	pg 10

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Features at www.MolinaHealthcare.com:

- Clinical Practice and Preventive Guidelines
- Disease Management Programs for Asthma, Diabetes, Hypertension, CAD, CHF and Pregnancy
- Quality Improvement Programs
- Member Rights & Responsibilities
- Privacy Notices
- Claims/Denials Decision Information
- Provider Manual
- Current Formulary & Updates
- Pharmaceutical Management Procedures
- UM Affirmative Statement (re: non-incentive for under-utilization)
- How to Obtain Copies of UM Criteria
- How to Contact UM Staff and Medical Reviewer
- New Technology

Molina Healthcare of Texas

Please contact Molina Provider Services for written copies of all information on the website or if you need more information please call Provider Services at 1-866-449-6849.

Managing Influenza and Pregnancy

Influenza is a common topic during this time of year. The severe influenza seasons of the past and not too distant pandemic highlights the importance of promoting the influenza vaccine and good hygiene etiquette to your patients annually. Although it's important for all persons 6 months and older to be protected by getting the influenza vaccine, particular emphasis should be put on those at high risk, especially women who are pregnant.

Pregnancy can add a layer of complexity when treating influenza. It's important to keep some key points in mind when managing your pregnant patients.

- **Encourage influenza vaccinations.** Pregnant patients who get influenza are at high risk for complications, so encourage vaccination regardless of trimester.

- **Treat influenza-like illness quickly.** Antiviral medications should be used as soon as possible to treat influenza-like illness. Educate your pregnant patients and staff on the signs and symptoms to look for. Establish procedures with staff to ensure early treatment after onset of symptoms.
- **Treat fever.** Fever can increase risk for certain birth defects. Acetaminophen is the recommended treatment for fever in pregnancy.
- **Keep updated with current treatment recommendations.** Recommendations may change, so it's important to watch for updates regularly. For the most updated information on influenza, visit the Centers for Disease Control and Prevention (CDC) at <http://www.cdc.gov/flu/professionals/>.

For more information on pregnancy and influenza, a prenatal toolkit is available on the CDC website at: http://www.cdc.gov/flu/pdf/freeresources/pregnant/2011_influenza_prenatal_toolkit.pdf

Source: Responding to Influenza: A Toolkit for Prenatal Care Providers, http://www.cdc.gov/flu/pdf/freeresources/pregnant/2011_influenza_prenatal_toolkit.pdf



HIPAA 5010 – Time Is Running Out

In a previous provider article, Molina Healthcare discussed the major changes coming down the pike under HIPAA: *the migration to the HIPAA 5010 transactions and the ICD-10 code sets*. With a compliance deadline of January 1, 2012, the clock is ticking and time is running out for providers and health plans to complete their migration to the 5010 standards.

Where Should We Be In Our 5010 Migration Plan?

All providers, trading partners and health plans should be aggressively pursuing Level II compliance which means completing end-to-end testing with their partners. For providers this means you should be working with your clearinghouse partner to make sure they are performing 5010 testing on your behalf. For health plans and trading partners this means that you should be directly testing with all trading partners and business associates.

What Is The Migration Process For Moving a Provider, Trading Partner or Business Associate to 5010?

The HIPAA 5010 compliance requirements dictate that all covered entities must be exchanging 5010 transactions as of January 1, 2012. However, it is allowable for any covered entity that has finished 5010 testing to start exchanging 5010 transactions immediately upon completion of successful testing (requires agreement between the entities exchanging 5010 transactions). For health plans it is desirable to move partners to a 5010 production status upon successful testing in order to prevent a huge backlog of activity in the 4th quarter of 2011. From a HIPAA perspective, both the 4010A1 and 5010 transaction standards are allowable for use during the period of March 17, 2009 through December 31, 2011.

What Does Dual Use Mean?

Many providers have mentioned to Molina Healthcare that they have heard the term “dual use” mentioned and are unclear as to what this means. Dual Use means that for a given transaction, both the 4010A1 and 5010 version of that transaction are supported in production. As an example, Molina Healthcare currently has the 835 outbound (payment, remittance advice) transaction in a dual use mode. This means that Molina Healthcare can send a business associate or other partner either a 4010A1 or 5010 version of the 835 transaction based on the business agreement between these two entities. Molina Healthcare will move all transactions into a dual mode status as each transaction is ready for 5010 production.

What Should a Provider Do To Prepare For 5010?

- Visit the CMS and WEDI websites to obtain education material on the 5010 standard
- Contact your practice’s software vendors to find out if they are upgrading their software to support 5010 compliance;
- Upgrade your practice management and other software as required to a 5010 compliant version;
- Conduct internal software testing to verify that you can properly send and receive 5010 transactions;
- If you use a healthcare clearinghouse to send and/or receive 5010 transactions, contact your clearinghouse account representative to confirm that they are 5010 compliant and make arrangements to start testing; and
- If you exchange 5010 transactions directly with any health plans, confirm that the plan is Level I 5010 compliant and contact them to initiate external testing of the 5010 transactions.

Continued on next page...

HIPAA 5010 – Time Is Running Out *Continued...*

Molina Healthcare's 5010 Readiness

Molina Healthcare has achieved Level I compliance and extensively involved with Level II external partner testing. Molina Healthcare is currently testing inbound and outbound 5010 transactions with clearinghouses, business associates and state and federal trading partners. Molina Healthcare has moved several 5010 transactions into a dual use mode. For additional information regarding Molina Healthcare's 5010 migration plans, please visit our website at www.MolinaHealthcare.com.



Access to Care

All Providers should follow the Access to Care Standards listed below. These standards are based on regulatory and accreditation standards. Molina Healthcare monitors compliance to these standards.

Appointment Availability/ Waiting Times for Appointments

- **Routine** exams should be provided within 14 days of request.
- **Preventive** health services for children within 60 days.
- **Preventive** health services for adults within 90 days.
- **Urgent** care should be received within 24 hours of the request.
- **Emergency** care should be received immediately.
- **Referrals** to a specialist should be seen within 30 days of a request.

Utilization Management (UM)

The Utilization Management (UM) department is open Monday through Friday from 8:00 am to 5:00 pm, except on state approved holidays. Feel free to call us at 1-877-665-4622 if you have any questions about the UM process. Should you call when the department is closed, you can leave a message, and someone will return your call the next business day between the hours of 8:00 am and 5:00 pm. Upon returning your call, Molina Healthcare will identify themselves by name, title and organization. Members who need language assistance can call 1-877-665-4622 for a bilingual representative. If a bilingual representative is not available, we will transfer the call to an interpreter to discuss UM issue at no charge to the member. If you have a patient who is hard of hearing please refer them to Relay Texas TTY at: 1-800-735-2929.

Our 2010 HEDIS® and CAHPS® Results

The Consumer Assessment of Healthcare Providers and Systems or the CAHPS® is a survey that assesses Molina member's satisfaction with their health care. It allows us to better serve our member.

Molina Healthcare has received the results of how our members scored our providers and our services.

Here are some areas they feel need improvement:

- Receiving the care they need faster
- Improved communication between provider and member

Our members also told us that we have improved in the following areas:

- Overall healthcare
- Satisfaction with the health plan
- Customer service

Another tool used to improve member care is the Healthplan Effectiveness Data Information Set or HEDIS®. HEDIS® scores allow Molina Healthcare to monitor how many members are receiving the services they need. Measures include immunizations, well-child exams, Pap tests and mammograms. There are also scores for diabetes care, and prenatal and after-delivery care.

Our HEDIS® scores improved in the areas of:

- Members with diabetes receiving cholesterol screening, hemoglobin A1C and protein tests.
- Prenatal care
- Compliance and adherence to asthma medication
- Adolescent immunizations
- Follow-ups post hospitalization
- Cholesterol checks for members with cardiovascular disease

Our HEDIS® scores show we need improvement in the areas of:

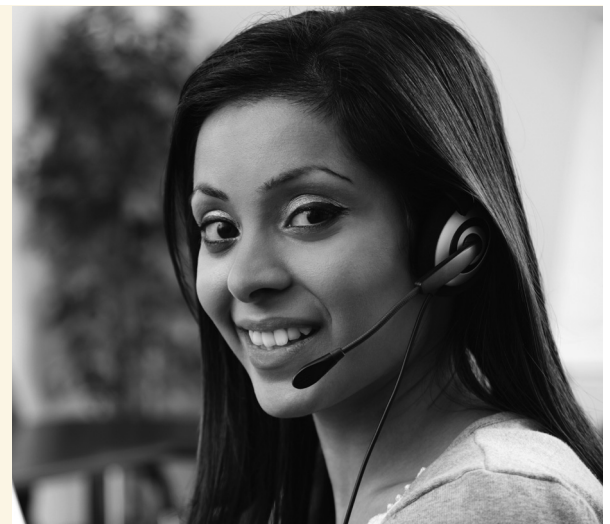
- Pap tests and mammograms
- Retinopathy screenings
- Childhood immunizations
- Chlamydia screenings
- Hypertension under control

To learn more or to request a copy of our Quality Improvement plan, call our Member Services Department at **1-866-449-6849**.

Nurse Advice Line

The Nurse Advice Line is here to help. Trained nurses are available to serve your patients 24 hours a day, seven days a week. If your patients have any concerns about their health, our specially trained triage nurses are available to listen to their symptoms, provide medical advice and make referrals to an appropriate care setting. Encourage your patients to call our Nurse Advice Line for assistance.

Nurse Advice Line: 1-888-275-8750 (English)
1-866-648-3537 (Spanish)



ICD-10 Introduction and Implementation Project

ICD-10 CM and PCS – What is That?

With all of the highly publicized changes underway in healthcare due to the Health Care Reform bill (Patient Protection and Affordable Care Act of 2010); it is easy to overlook the less high profile, but still major change coming under HIPAA: **the ICD-10 code sets**. With a compliance deadline of October 1, 2013, covered entities including providers, vendors, clearinghouses and health plans should understand what it takes to complete their conversion to the *ICD-10 code sets*.

Why is it required to switch from ICD-9 codes to ICD-10 codes? The health care industry has been using ICD-9 codes for nearly 30 years and they just have not been able to keep up with the changes in medicine, the newer conditions and with the newer ways of treating patients. The ICD-10 diagnosis code set has been designed to capture much more specific information on the patient's diagnosis. The procedure code set will enable hospitals to record much more specific information on procedures performed and devices used.

What is ICD-10 and how does the change impact healthcare providers?

The ICD-10-CM **diagnosis code set** includes significant improvements over the International Classification of Diseases, 9th Edition, Clinical Modifications (ICD-9-CM). There are currently approximately 14,000 ICD-9 diagnosis codes compared to over 69,300 ICD-10 diagnosis codes.

The ICD-10-PCS **Procedure Coding System** provides detailed codes to describe complex medical procedures for use on inpatient hospital claims at a much more granular level than its ICD-9 counterpart. There are currently approximately 3,800 ICD-9 institutional procedures codes compared to nearly 72,000 ICD-10 institutional procedures codes (PCS). ICD-10-PCS will not be used on physician claims, even those for inpatient visits. The Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) will continue to be the code sets for reporting ambulatory procedures.

As HIPAA covered entities, providers, their vendors and clearinghouses must convert to the new ICD-10 code sets for claims and/or encounters submission with dates of services or date of discharge on or after October 1, 2013.

What Should a Provider Do To Prepare For ICD-10?

- Visit the CMS websites to obtain education material on the ICD-10 mandate
- Contact your practice's software vendors to find out their approach and timeline to support ICD-10 compliance;
- Conduct internal assessments across people, process and technology to determine impacts and level of effort required;
- Collect information from each department on current use of ICD-9 and the number of staff members who need ICD-10 resources and training. Staff training will most likely involve billing and other financial personnel, coding staff, clinicians, management, and IT staff
- If you use a healthcare clearinghouse to send claims and/or encounters, contact your account representative to confirm that they are 5010 compliant and will be able to submit ICD-10 compliant transactions on your behalf; and
- If you submit claims directly with any health plans, confirm what the plan's timeframe and testing approach will be and contact them to initiate that dialogue.

What are the benefits to this code set change?

On the administrative side, the codes provide more information on the claim. There should be less need to request additional information from our providers to make payment decisions, so claims adjudication for this purpose should not be delayed.

With the greater specificity of ICD-10-CM diagnoses and ICD-10-PCS procedure codes, claims information can be used for data capture and analysis.

Pay for performance and provider quality measurement are key drivers in today's health care world. Many of the measures used for these efforts are based on specific diagnoses. With ICD-10, we have an opportunity to develop more targeted and more accurate quality measures, since we have better diagnosis information. This also gives us the opportunity to improve quality measurement and pay for performance, which should lead to better quality health care for our members

Molina Healthcare's ICD-10 Readiness

Molina Healthcare has completed an enterprise-wide detailed impact assessment and has conducted initial surveys with our trading partners, business associates, vendors and providers. Timeline and important information will be shared in the near future. Be on the lookout for additional information in subsequent newsletters.

Medicare Section

Medicare Special Needs Population (SNP)

What is the Interdisciplinary Care Team (ICT)? Molina Medicare provides an Interdisciplinary Care Team to help coordinate Molina member's interactions with all the professionals, organizations and facilities involved in their care.

The core of this ICT is you, the physician, as the director of the patient's plan of care. Molina's role is to support and partner with you to help ensure the member can follow through on your instructions and has access to the care you have ordered. The Molina team may also be able to share information about your patient's care from the patient themselves, their caregivers and other parts of the healthcare system that you may not have access to.

The Molina portion of the ICT is a multidisciplinary team of nurses, medical directors, social workers, pharmacists, health educators and behavioral health staff ready to help your patient navigate through the health care system. Molina also provides a network of

specialty and ancillary providers and facilities to help in the care of your patients who are also part of the ICT.

Molina staff will be your eyes and ears by communicating with members and other health care professionals to identify and overcome barriers to care. Regular updates will be sent to you to keep you informed on your patient's activities and progress across the healthcare spectrum.

How can you help? Encourage your patient to work with Molina Clinical staff and to take an active role in improving their health. Allow Molina to share health information with you that may assist you in providing care for your Molina patients. Together we can make a difference! For more information on the Molina Medicare Special Needs Plan Interdisciplinary Care Team and Model of Care please go to our website www.MolinaMedicare.com



The Affordable Care Act and Medicare Star Ratings – The Provider’s Role

With the passage of the Affordable Care Act, the healthcare industry will be subject to greater scrutiny wherever taxpayer dollars are involved. One method of oversight is Medicare “Star Ratings”. Star ratings are not new, but in the current regulatory climate, value-based payment will be receiving more focus.

What are Star Ratings?

Star Ratings are a system of measurements CMS uses to determine how well physicians and health plans are providing care to Medicare members. This system is based on nationally-recognized quality goals such as “The Triple Aim” and the Institute of Medicine’s “Six Aims”, which focus on improving the health and care of your patients, safe and effective care, as well as making care affordable. These aims are realized through specific measures, such as:

- Access to Preventive Care – are your patients getting in to see you at least once a year?
- Screenings –
 - are your patients getting timely glaucoma screenings?
 - are your diabetic patients’ annual (or more) HbA1c test results under 9.0%?
- Patient survey questions – “...rate your satisfaction with your personal doctor.”

What Can Physicians Do?

Here are some places to start:

- Ensure your patients are up-to-date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology.

- Review the HEDIS® preventive care listing of measures for each patient you see to determine if you have missed anything applicable to your patients’ age and/or condition.
- Check that your staff is properly coding all services you provide (see example below).
- Be sure your patients understand what *they* need to do.

Doing well on Star Ratings measures benefits both you and your patient. We are happy to help you take the next step.

Example of HEDIS® CPT/ICD-9 code sheet you can use in your practice (available at www.MolinaMedicare.com):

Comprehensive Diabetes Care - Age: 18-75 Years - Codes to Identify Diabetes	
Description	ICD-9-CM Codes
Diabetes	250, 357.2, 362.0, 366.41, 648.0
Codes to Identify Outpatient Visits	
Description	CPT Codes
Outpatient	92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456
Codes to Identify HbA1c Testing	
CPT Codes	CPT Category II Codes
83036, 83037	3044F, 3045F, 3046F

Molina Medicare has additional resources to assist you and your patients!

For access to tools that can assist you in your practice, please go to our Molina Medicare website at www.MolinaMedicare.com and click on Providers. You will find a variety of resources, including:

- HEDIS® CPT/ICD-9 code sheet (as shown above)
- A list of HEDIS® & CAHPS® Star Ratings measures
- Article archive

¹ HEDIS® and CAHPS® are registered trademarks of the National Committee for Quality Assurance (NCQA)

A Clinical Concern for Older Patients: Anticholinergic Medication Use Linked to Cognitive Impairment and Higher Mortality

A recent study has found that anticholinergic medications, many of which are commonly used to treat multiple conditions in the older population, may increase the risk of cognitive impairment and death in older adults. The study assessed prescription and OTC medications in over 12,000 men and women over the age of 65.

The results of the study were:

- 48% of patients reported taking medications with anticholinergic properties.
- For those patients significantly cognitively impaired at baseline, mortality was strongly related to a higher anticholinergic side effect profile.
- For patients with higher anticholinergic side effect profiles, higher cognitive impairment was found at baseline as well as greater cognitive decline at re-measurement.
- Higher risk of mortality was found for patients taking anticholinergics with higher side effect profiles, with odds increasing 26% for each additional side effect ranking point.



The results of this study highlight the importance of regular review of older patients' medications. In light of these findings, it is also important to emphasize that **Molina Medicare has services to help support you in the management of your Molina Medicare Members.** Molina Medicare has a medication therapy management program² through our pharmacy department in which our pharmacists complete a clinical assessment with your patients. We work to collaborate with you regarding medications (such as evaluating at-risk medications, above) and compliance. The Pharmacy department has additional information; please contact the department for assistance.

Molina Medicare has additional resources to assist you and your patients:

- Pharmacy line for Physicians: 1-888-562-5442, extension 179787
- Molina Medicare website – Formulary, Prior Authorization, Step Therapy Criteria, and more
 - Located at www.MolinaMedicare.com
- Disease Management programs for Asthma, Diabetes, COPD and Cardiovascular diseases
 - Call 1-866-891-2320 for more information

¹ Fox, Chris, MD, Richardson, Kathryn, MSc et al. Anticholinergic Medication Use and Cognitive Impairment in the Older Population: The Medical Research Council Cognitive Function and Ageing Study. *J Am Geriatr Soc* 2011;10.1111/j.1532-5415.2011.03491.x

² Ancelin ML, Artero S, Portet F et al. Non-degenerative mild cognitive impairment in elderly people and use of anticholinergic drugs: Longitudinal cohort study. *BMJ* 2006;332:455-459.

³ Members must meet certain criteria for enrollment in the medication therapy management program.

Coordination of Care during Planned and Unplanned Transitions for Medicare Members

Molina Medicare is dedicated to providing quality care for our Medicare members during planned or unplanned transitions. A transition is when members move from one setting to another, such as when a Molina Medicare member is discharged from a hospital. By working together with providers, Molina Medicare makes a special effort to coordinate care during transitions. This coordination of specific aspects of the member's transition is performed to avoid potential adverse outcomes.

To ease the challenge of coordinating patient care, Molina Medicare has resources to assist you. Our Utilization Management nurses and Member Services staff are available to work with all parties to ensure appropriate care.

In order to appropriately coordinate care, Molina Medicare will need the following information in writing from the facility *within one business day* of the transition from one setting to another:

- Initial notification of admission within 24 hours of the admission
- Discharge plan when the member is transferred to another setting
- A copy of the member's discharge instructions when discharged to home

This information can be faxed to Molina Medicare at:
(888) 802-5711

To assist with the discharge planning of Molina Medicare members, please note the following important phone numbers:

- **Medicare Member Services & Pharmacy:** (866) 440-0127
- **Behavioral health** services and substance abuse treatment for Molina Medicare members can be arranged by contacting: (888) 825-9266 Option 3, 2

- **Transportation** services for Molina Medicare Options Plus Members may be arranged by calling **MTM at 1-866-867-3208**.
- The **Nurse Advice Line** is available to members 24 hours a day, 7 days a week at **(888) 275-8750**.

Important information you need to know about Molina Medicare Options Plus:

- All beneficiaries have rights that are defined in our provider manual. They are also available in the member EOC posted on our website at **www.MolinaM--edicare.com**.
- Molina Medicare Options Plus members have Medicare and Medicaid benefits designed to meet their special needs, therefore the state agency or its designated health plans have the responsibility for coordinating care, benefits and co-payments. Please be aware of your patients' status & Medicaid benefits and bill the correct entity.
- Health plans and providers can never charge these members more than they would have paid under Original Medicare and Medicaid. Members can also call the Medicaid agency for details and have specific rights with regard to their Medicaid benefits.
- Providers are responsible for verifying eligibility and obtaining approval for services that require prior authorization as outlined in the Provider contract. Our Medicare Member Services department can assist you in this regard.

Please contact the UM Department at **or Medicare Member Services** if you have questions regarding planned or unplanned transitions at:

UM Department: (888) 825-9266 Option 3, 2
Member Services: (866) 440-0127