Molina Healthcare is excited to announce the launch of Clear Coverage!

Submit Authorizations Online through Web Portal and Receive Real Time Responses, Including Automatic Authorizations!

What are the benefits?
Easy to access 24/7 online access to Clear Coverage
- Receive real time authorization status by viewing your office's home page in Clear Coverage
- Automatic APPROVALS for many services
- Services not automatically approved are immediately uploaded into Molina Healthcare's authorization system and queued for clinical review
- Ability to upload medical records
- Verify member eligibility
- Ability to print proof of authorization

How does it work?
Access Clear Coverage through the Molina Healthcare Provider Web Portal
- Take the online Clear Coverage training. Takes approximately 30 minutes to complete
- Schedule an on-site Clear Coverage Training by contacting your Provider Service Representative

Want to learn more?
Visit the Molina Healthcare Provider Web Portal
- Contact your Provider Service Representative today

If you have any questions or concerns, please contact Provider Services Department: Kelly Vetoich at (855) 322-4077 ext. 155822 Monday through Friday between 8:00am and 5:00pm. Thank you for your continued services to Molina Healthcare members.

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Claims Submission Requirements
If you do not file electronically:
Please mail all initial Medicaid/MIChild claims to:
Molina Healthcare, Inc.
P.O. Box 22668
Long Beach, CA 90801

Please mail all initial Medicare claims to:
Molina Healthcare Options Claims
P.O. Box 22811
Long Beach, CA 90801

Please do not submit initial claims to the Troy address as this will delay the processing of your claims, and your claim may be returned. Please contact the Claims Department with any questions or concerns at (888) 898-7969.
Healthy Michigan Plan

Governor Rick Snyder signed into law Michigan Public Act 107 of 2013, which allows the State of Michigan to make health care benefits available to low-income Michigan residents through the Healthy Michigan Plan in early spring 2014. The Healthy Michigan Plan will encourage healthy behaviors and personal responsibility, help low-income Michigan resident’s access affordable health coverage, and reduce uncompensated care that shifts costs onto businesses and taxpayers.

The Healthy Michigan Plan will cover people who are:

- Ages 19-64
- Not currently eligible for Medicaid
- Not eligible for or enrolled in Medicare
- Not pregnant when applying for the Healthy Michigan Plan
- Earning up to 133% of the Federal Poverty Level – approximately $15,000 for single person and $34,000 for a family of four
- A resident of Michigan

Physicians are not responsible for collecting copays from Healthy Michigan Plan patients. Healthy Michigan patients will have copays; however health plans are responsible for collection.

If you have Adult Benefit Waiver patients, they will automatically transition to the Healthy Michigan Plan on April 1. PLEASE NOTE: The state has already notified these patients of the change (by mail).

Other covered services will include medically necessary services as prior authorized, as well as other services required to be covered pursuant to state or federal law, regulation or policy.

Healthy Michigan Plan covers family planning services with no out-of-pocket cost to patients.

Dental services will be provided by a dental network selected by Molina. Participants will not be denied coverage due to pre-existing conditions.

To help ensure patient accountability for healthy behavior and to engage patients in their own care, Healthy Michigan Plan members will be required to do ALL of the following:

2. Within 60 days of enrollment, schedule a visit with a primary care physician.
3. Visit a primary care physician within 150 days of enrollment.

You can get more information on the Healthy Michigan Plan by visiting Michigan.gov/healthymichiganplan.
Molina will reimburse $250.00 to physicians whose members qualify for a Medicare Health Evaluation Assessment.

Molina gears up for its 2014 Medicare Health Evaluation Program

*Molina Healthcare prepares for Physician Completed Assessments –
Highlights Interview with Dr. Susan Rice*

Molina Healthcare Inc. is launching its 2014 Medicare Health Evaluation Program and will use a successful health assessment tool – the Annual Comprehensive Exam form – to drive accuracy in identifying risk factors and obtaining important information relating to its Medicare members’ overall health status. Revised and scaled down to maximize the annual face-to-face visit, the new ACE form compliments the chronic disease consultation with the member’s primary care physician. The Annual Comprehensive Exam can be completed during the annual physical and/or extended office visit.

What do you find beneficial in completing Molina health assessments?
Dr. Rice: The health assessments make me think comprehensively about each patient.

Do you find it too time consuming?
Dr. Rice: No. The health assessments probably require an extra 15 minutes with a patient while doing their annual physical. According to Rice, “it’s time well spent to review their history, current complaints, and physical findings and develop a problem list.”

Although the incentive is a reward, what do you find the exam bring to managing the member’s health and chronic conditions?
Dr. Rice: Dr. Rice states, “The form makes me aware of opportunities to evaluate and enhance the member’s health. It helps in treatment planning related to physical health deficits and maintenance needs.”

Since this will be the second year you will be completing the forms, what do you think of the new format?
Dr. Rice: Rice concludes, “The whole form is patient focused, from Preventive Health Counseling to the Functional Assessment section. Among other things, the activity listed makes me assess each senior’s fall risk and their ability to bath and feed themselves. It is obvious on the form and it keeps me on point in case I am in the exam room and cannot remember to cover all aspects of the exam. We use the information the rest of the year and it helps that the new format includes pre-populated sections that helps in quickly completing the form.”

Dr. Susan Rice has been a primary care physician for over 32 years and renders her services to the citizens of Detroit and the Metropolitan area as one of Molina Healthcare’s finest physicians. The Molina Medicare Health Evaluation Program (HEP) is designed to improve coordination of care for its Medicare members. Molina’s goal is to have every Medicare member seen by their PCP annually during their membership with Molina. For more information about the 2014 Medicare Health Evaluation Program please contact Delois Spearman at (866) 449-6828 ext 155377.
Help members to quit, and get paid for it!

Molina Healthcare works with our physician partners to increase our HEDIS Advise Smokers to Quit (ASQ) rates. To support you in the effort, Molina Healthcare reimburses you for each tobacco cessation counseling session up to 12 sessions per member per year in all Molina Healthcare product lines except county health plans.

**Tobacco cessation reimbursement tips**
Use the correct diagnosis code: 305.1 – Tobacco Use Disorder

**Codes for billing**
99406 – Smoking and tobacco-use cessation counseling visit; intermediate, greater than three minutes up to 10 minutes. Short Descriptor: Smoke/Tobacco counseling 3-10.

99407 – Smoking and tobacco-use cessation visit; intensive, greater than 10 minutes. Short Descriptor: Smoke/Tobacco counseling greater than 10.

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**Integrated or Collaborative Care**

“Integrated or collaborative care” is how APA President-elect Paul Summergrad, M.D. characterizes the coordination of care between providers for members who have psychiatric disorders, which includes substance use disorders, and general medical illnesses.

The National Committee for Quality Assurance directly holds health plans accountable through its quality standard QI 11 titled “Continuity and Coordination Between Medical Care and Behavioral Healthcare.” Specifically on an annual basis Molina measures:

- The % of members the PCP assessed for depression
- The % of members the PCP assessed for drug or alcohol use
- The % of members the PCP screened for suicide risk
- The % of members the PCP referred to a behavioral health provider
- The % of medical records in the PCPs office that included a diagnosis from a behavioral health provider, and
- The % of medical records in the PCPs office that included an individualized treatment plan from a behavioral health provider

The importance of detection, screening and coordination of care in the PCPs office is the essential first step in patient-centered care.
HEDIS UPDATE

New National Committee for Quality Assurance (NCQA) Requirement

NCQA now requires any information related to HEDIS results must be accompanied with proof of service. Documentation of proof of service may be in the form of a progress with the following on it:

- Note dated and signed by the provider
- Date of service
- Type of service
- Result or a copy of the original report containing the documented results.

Examples of documentation would include LDL, HbA1c, Bun, Creatinine, BMI, BP, Colonoscopy, Mammogram or Cervical Cancer Screen.

This is the only method we can accept and be able to grant credit for HEDIS services performed.

Reminder!

Providers does your afterhours message ensure that Molina members have 24 hours access to you or an on-call physician? Do they know what to do in case of an emergency? Here's a few helpful hints!!!!

1. Emergency Instructions for members:
   a. Hang up and dial 911 or go to the ER
   b. Stay on the line to be connected
   c. Give another number
   d. Physician can be paged

2. How to reach an on-call physician:
   a. Stay on the line to be connected
   b. Leave name and number
   c. Physician can be paged or reached
   d. Give another number
Molina Initiates Depression Screening for Members in Case Management

Medical literature has demonstrated a close association between depression and other medical illness. Studies of chronic medical disease reveal rates of depression that are two to five times higher amongst those suffering from chronic medical illness. When both chronic illnesses and depression are present, it is important to treat both at the same time to promote better outcomes.

Depression-screening tools can help reduce the likelihood of misdiagnosing depression or prescribing medications for patients who may not be clinically depressed. Measuring the outcome of treatment through the systematic use of a depression-screening tool can help with depression tracking and assist practitioners in determining the efficacy of a current treatment regimen. Depression screening may aid practitioners in determining when psychotherapy, medication changes, or a specialty referral should be considered.

Molina case managers have begun screening members enrolled in case management for depression via the Patient Health Questionnaire-2 (PHQ-2) a brief, two-question tool to screen for possible depression.

When a member scores positively on the PHQ-2, he/she is referred to his/her primary care physician for further screening. The primary care physician will receive a letter indicating that their member screened positive for possible depression. Included in the letter is the Patient Health Questionnaire-9 (PHQ-9) and scoring tool for primary care physicians.

Practitioners can also download the Patient Health Questionnaire–9 (PHQ-9) from the provider portal on our Website at www.Molinahealthcare.com. Molina’s Behavioral Health department is available to consult with practitioners on coordinating services. Please also note members may self-refer for behavioral health services.

Molina has adopted the Michigan Quality Improvement Consortium (MQIC) “Primary Care Diagnosis and Management of Adults with Depression” guidelines. To access these guidelines you may go directly to the MQIC Website at www.MQIC.org where you can find the most updated guidelines and physician tools on management of members with depression, including information about assessments, medication management and behavioral health treatment.

To refer a patient for behavioral health services, and to facilitate the coordination of treatment, please call Molina’s Behavioral Health department at 888-898-7969.

Claims

“In order for us to serve you more efficiently we are asking that you contact our provider claims service reps to assist you with your claims inquiries. For future reference please be sure to call 855-322-4077, press 1 for Medicaid, press 3, non-pharmacy claims, and then press 4 for all other claim inquiries. This will get you directly to a claims Service Representative. Thank you.
FRAUD, WASTE, AND ABUSE RECAP

Molina Healthcare of Michigan seeks to uphold the highest ethical standards for the provision of health care benefits and services to its members. Molina Healthcare of Michigan regards health care fraud as unacceptable, unlawful, and harmful to the provision of quality health care in an efficient and affordable manner.

What is Medicaid Fraud, Waste and Abuse?

“Fraud” means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 Code of Federal Regulations Section 455.2)

“Waste” means overutilization of healthcare services, devices and prescriptions

“Abuse” means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, 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 Medicaid program. (42 Code of Federal Regulations Section 455.2)

Examples of Provider Fraud, Waste and Abuse:

Falsification of Information – False coding, records or altered claims. Billing for services not rendered or goods not provided.

Questionable Practices – Billing separately for services that should be a single service. Billing for services not medically necessary

Overutilization – Medically unnecessary diagnostics; unnecessary durable medical equipment; unauthorized services; inappropriate procedure for diagnosis.

Instances of known or suspected fraudulent healthcare activity can be reported anonymously:

Molina Healthcare     or   Michigan Department of
Attn: Compliance Director      Community Health
100 W. Big Beaver Road, Suite 600      Attn: Office of Inspector General
Troy, MI 48084      PO Box 30479
1-866-606-3889       Lansing, MI 48909
https://molinahealthcare.alertline.com    1-855-643-7283
www.michigan.gov/fraud
Patients with Complex Needs Receive Personalized Support from Molina

Molina Healthcare of Michigan is committed to providing our members with support and education in managing their chronic health conditions. Case Management is a voluntary program that is available to Molina’s adult and pediatric members at no cost. Case Managers provide support and education to members in managing the below conditions.

- Asthma
- Chronic obstructive pulmonary disease
- Heart failure
- Diabetes
- High risk pregnancy
- Transplants
- HIV/AIDS
- Cancer
- Kidney Disease
- Cardiovascular Disease
- Hypertension
- Sickle Cell Anemia
- Substance Use
- Mental Illness

Through Molina’s Health Management and Case Management programs, member’s needs are assessed and members are stratified into the most appropriate level of Health Management. Members with chronic conditions who require less care coordination are enrolled in the Health Management Program and receive education about their condition, diet, exercise, and medication. Members with complex medical needs can receive personalized support from Molina’s Case Management department.

Molina provides members with educational booklets that address topics such as Diabetes, Asthma, Stress and Depression, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Hypertension Coronary Artery Disease, Help to Quit Smoking, Pregnancy, Kids and Diabetes, Kids and Asthma, etc. Molina’s Health Management program focuses on providing support and education to members with high acuity Asthma and Diabetes.

Through Molina’s Case Management Program, members receive a comprehensive assessment to identify physical and mental health conditions. The assessment addresses issues such as activities of daily living, support systems, cultural needs, medication compliance, cognition, and preventative health needs. In collaboration with the member, an RN Case Manager develops an individualized care plan and goals are established to facilitate the member managing their health conditions. The member and the Case Manager identify barriers that may be preventing the member from achieving their healthcare goals. The member’s barriers are addressed in order to facilitate the member meeting their goals.

Case Managers provide education to members on an ongoing basis regarding their health conditions, encourage members to make lifestyle changes in order to promote wellness, and assist in coordination of care to assure that members obtain the care and services that they require. Members are educated regarding obtaining care from their primary care physician in order to promote continuity of care. Member are educated in areas such as keeping appointments with their specialists, take their medication as prescribed, maintaining a healthy lifestyle through proper nutrition, physical activity, and smoking cessation. Case Managers work with members to promote health and wellness resulting in improved member health and wellness, decreased Emergency Department visits and decreased hospital admissions.

To learn more about Molina’s case management program or refer a member to one of our programs, call us at 1-888-898-7969 from 8:30 a.m. to 5 p.m. Monday through Friday.
Web Portal Updates for our Michigan Providers!

Check out the improvements and new features available on Molina Healthcare's online, self-service web portals! To log on or register, please visit www.MolinaHealthcare.com.

Clear Coverage™

a. The Clear Coverage™ application, a McKesson a product, is now available in the Provider Portal! With this tool, our providers can submit authorizations online and receive real-time statuses, including automatic approvals for many services.

Health Insurance Marketplace

b. Providers will be able to manage their Molina Marketplace members via the Provider portal including the ability to view members’ eligibility and benefits information and submit prior authorizations and claims.

c. Existing providers will not need to re-register. The Marketplace line of business will be available to them.

High-Risk Flu Report

d. Via the Provider portal, providers will have the ability to view and print a provider-specific report of members that are at high risk of complications for flu.

Member Personal Health Records and Care Plan

e. In the “Eligibility and Benefits” section of the Provider Web Portal, providers can view their members’ Personal Health Records such as lab results, allergies, and medications.

f. Providers will also be able to view their member’s Care Plan, if applicable.

g. This new feature is also available in MyMolina.com (Member Portal).

Behavioral Health

Primary Care Providers provide Medicaid outpatient behavioral health services, within the scope of their practice, and are responsible for coordinating members’ physical and behavioral health care, including making referrals to Behavioral Health providers when necessary. If you need assistance with the referral process for Behavioral Health services, please contact the Member services Department at (888) 898-7969.
Molina Healthcare’s Utilization Management

One of the goals of Molina Healthcare Health Care Services (HCS) Department is to render appropriate UM decisions that are consistent with objective clinical evidence. To achieve that goal, Molina Healthcare maintains the following guidelines:

- Medical information received by our providers is evaluated by our highly trained HCS staff against nationally recognized objective and evidence-based criteria. We also take individual circumstances and the local delivery system into account when determining the medical appropriateness of requested health care services.

- Molina Healthcare’s clinical criteria includes McKesson InterQual® criteria, Hayes Directory, Medicare National and Local Coverage Determinations, applicable Medicaid Guidelines, Molina Medical Coverage Guidance Documents (developed by designated Corporate Medical Affairs staff in conjunction with Molina Healthcare physicians serving on the Medical Coverage Guidance Committee) and when appropriate, third party (outside) board-certified physician reviewers.

- Molina Healthcare ensures that all criteria used for UM decision-making are available to practitioners upon request. To obtain a copy of the UM criteria used in the decision-making process, call our UM Department at 1-888-898-7969.

- As the requesting practitioner, you will receive written notification of all UM denial decisions. The notification will include the name and telephone number of the Molina Healthcare physician that made the decision. Please feel free to call him or her to discuss the case. If you need assistance contacting a medical reviewer about a case please call the HCS Department at 1-888-898-7969.

Molina Healthcare’s HCS Department staff is available for inbound collect or toll-free calls during regular business hours to provide information about the UM process and the authorization of care. If you wish to speak with a member of the HCS staff, please call (888) 898-7969. You may also fax a question about a UM issue to (800) 594-7404. The Medical Director is available for more complex medical decision questions and explanations of medical necessity denials.

Molina Healthcare’s regular business hours are Monday – Friday (excluding holidays) 8:30 a.m. – 5:00 p.m. After normal business hours are Monday – Friday 5:00 p.m. – 8:30 a.m., including Saturday, Sunday and holidays. Voicemail messages received after regular business hours will be returned the following business day. Molina Healthcare has language assistance and TDD/TTY services available for members with language barriers or with hearing and/or speech problems.

It is important to remember that:

1. UM decision making is based only on appropriateness of care and service and existence of coverage.

2. Molina Healthcare does not specifically reward practitioners or other individuals for issuing denials of coverage or care.

3. UM decision makers do not receive incentives to encourage decisions that result in underutilization.
Molina Healthcare’s Utilization Management - *Continued*

4. Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage.

5. Medicaid members have the right to a second opinion from a qualified practitioner. If an appropriate practitioner is not available in-network, Molina Healthcare will arrange for a member to obtain the second opinion out of network at no additional cost to the member than if the services were obtained in-network.

6. Some of the most common reasons for a delay or denial of a request include:
   - Insufficient or missing clinical information to provide the basis for the making the decision,
   - Lack of or missing progress notes or illegible documentation, and/or
   - Requesting an urgent review when there is no medical urgency.

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**Provider Claims Appeals and Correct Claims Process:**

Molina Health Plan of Michigan has an appeal process for Medicaid & Medicare claims when the provider has received a claim code edit or timely filing ‘denial’. Following the steps of the appeal process is very important to resolve unpaid claims.

1. Fill out an ‘adjustment form’ for *each* claim. Five claims = five adjustment forms.
2. You have two options when resubmitting your claim(s) appeals: fax or regular mail

Fax the form(s) and any appropriate documentation to: *(248) 925-1768*

Mail service: send a hard copy form/claim to:
**Molina Healthcare of Michigan: 100 W. Big Beaver Rd, Suite 600, Troy, MI. 48084.**

**For Corrected Claims:**
If there are any changes to the claim, for example, a modifier, CPT, or DX code have changed, this is defined as a corrected claim and not an appeal.

Please be sure to note the correction made in box 19, and enter a 7 *and* the original claim number in box 22 for both Medicaid and Medicare claims. If you are sending a corrected claim, please be sure to complete all line items on the claim form, and not just the line that denied. If all lines are not completed, it will not match the original claim, and will be viewed as a new claim which will trigger a “duplicate” claim denial. Send the corrected claim either by EDI to the appropriate clearing house or Paper copies to:

**Medicaid Claims:** P.O. Box 22668 Long Beach, CA, 90801

**Medicare Claims:** P.O. Box 22811 Long Beach, CA, 90801

Please be sure to read the original reason for the denial, so that the same error is not made on the resubmitted corrected claim.
Molina Patients with Questions About Their Health?

Call Our Nurse Advice Line!

English: (888) 275-8750
Spanish: (866) 648-3537

OPEN 24 HOURS!

Your family’s health is our priority! For the hearing impaired, please call

TTY (English): (866) 735-2929
TTY (Spanish): (866) 833-4703
or 711

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