Molina Dual Options MyCare Ohio
Medicare-Medicaid Plan FAQ's

Coverage and Benefits

Q: What is the Molina Dual Options MyCare Ohio Medicare-Medicaid Plan?

A: Molina Dual Options is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees. Individuals who are eligible for Medicare *and* Medicaid coverage and who live in one of the MyCare Ohio service areas can choose a MyCare Ohio plan, or one will be assigned to them. There are many benefits to being a Molina Dual Options member, including maximized coverage.

Q. What is Medicaid Only (opt-out) and how is it different from Molina Dual Options (opt-in)?

A. Individuals eligible for a MyCare Ohio Plan may choose to opt-out of the Molina Dual Options plan and enroll in Molina MyCare Ohio Medicaid as "Medicaid Only members." These members are enrolled solely for Medicaid benefits, while maintaining traditional Medicare or a Part C (Medicare Advantage) plan that is not contracted through MyCare Ohio.

Q. How do providers know in which Medicare plan the patient has enrolled and when the patient has made a plan change?

A. Ohio's Medicaid Information Technology System (MITS) portal will continue to provide Medicare plan information as provided by the Centers for Medicare and Medicaid Services (CMS); no changes have been made to this process. MyCare Ohio enrollment is available on the MITS portal, documenting the individual's MyCare Ohio plan.

Q. How often can a MyCare Ohio patient change plans?

A. Patients enrolled in MyCare Ohio can change their Medicaid plans for the first three months after initial enrollment, and during the annual open enrollment period. The Ohio Department of Medicaid (ODM) sends open enrollment notices to patients once a year. Patients may choose to opt-in or opt-out of the Medicare portion on a monthly basis.

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Q. Does a MyCare Ohio patient have to reapply for Medicaid each year to maintain eligibility?

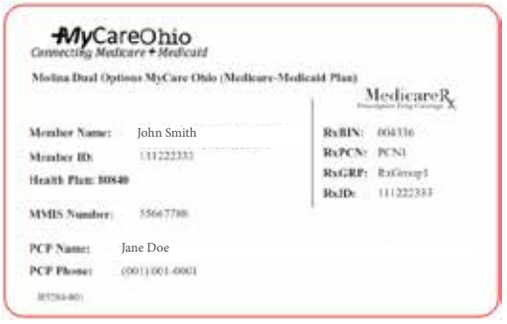
A. Yes, eligibility for Medicaid is maintained by the County Department of Job and Family Services, and MyCare Ohio enrollment does not change the eligibility process. Because an individual must be eligible for Medicaid to be enrolled in MyCare Ohio, Medicaid redetermination still applies to all MyCare Ohio patients.

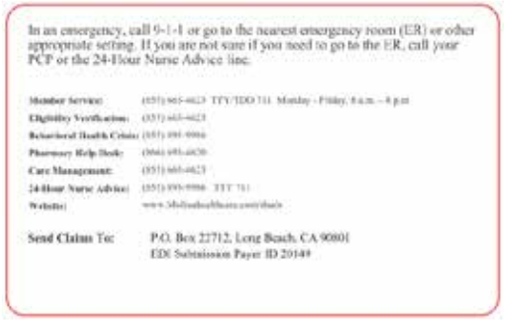
MyCare Ohio patients are required to report their household income every 12 months to verify their Medicaid eligibility in a process called Medicaid redetermination. Patients can choose to enroll in passive verification, which will automatically verify their eligibility every 12 months for up to five years. For more information about Medicaid redetermination, read the Medicaid Redetermination FAQs.

Q. What do the member ID cards look like? How can I tell if the patient is a Molina Dual Options or Molina MyCare Ohio Medicaid Only member?

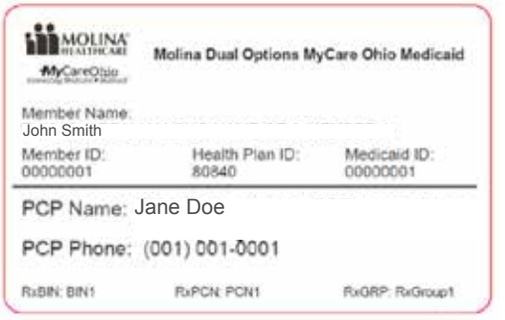
A. The following are examples of the MyCare Ohio member ID cards. On the left is the front and back of the Molina Dual Options member ID card and on the right is an example of the Molina MyCare Ohio Medicaid Only member ID card. Please note that for the Molina MyCare Ohio Medicaid members, the card says Molina Dual Options MyCare Ohio Medicaid and does not contain Medicare Rx information.

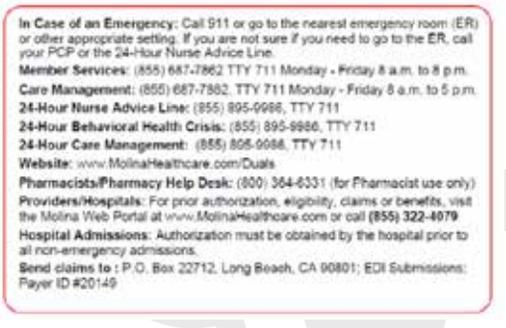
Molina Dual Options Member ID Card





Molina MyCare Ohio Medicaid Member ID Card





Q: Is there a change in the coordination of benefits process for MyCare Ohio patients?

A: According to ODM, there should be no practice change for coordination of benefits during the three-year demonstration period. This means that if a Medicare-eligible service is provided by a non-Medicare eligible professional, the service can and will be reimbursed by Medicaid as the primary payer. Medicare, however, will not automatically cross claims over to Molina Healthcare for secondary processing. It will be the responsibility of the provider to send secondary claims to Molina Healthcare for processing. This applies to Molina MyCare Ohio Medicaid Only members. For Molina Dual Options members, there is no coordination of benefits, as Molina Healthcare covers both Medicare and Medicaid and will be both the primary and secondary payer.

Q. What is the Transition of Care (TOC) period?

A. In order to minimize service disruption, Molina Dual Options continues to honor the individual's existing service levels and providers for a pre-determined amount of time, depending on the type of service. The TOC period for most services is 365 days or 90 days for high-risk individuals with the following exceptions:

- Dialysis treatment has a 90-day transition period.
- Medicaid nursing facility (NF) services and the assisted living waiver services will be maintained for the life of the demonstration.
- Molina Dual Options is required to honor prior authorizations (PAs) for durable medical equipment (DME) if the item has not been delivered, and must review ongoing PAs for medical necessity.
- Molina Dual Options is required to honor a specified provider for scheduled surgeries.
- Chemotherapy/radiation treatment initiated prior to enrollment must be authorized with the specified provider through the course of treatment.
- Behavioral health services transition period is extended to Dec. 31, 2015.

Q. Is the TOC period shortened for any reason?

A. During the TOC period, change from the existing services or provider can occur in any of the following circumstances:

- Patient requests a change
- Significant change in patient's status
- Provider gives appropriate notice of intent to discontinue services to a patient
- Provider performance issues are identified that affect an individual's health and welfare

  ► Note: Plan-initiated change in service provider can only occur after an in-home assessment and development of a plan for the transition to a new provider.

Q. What are the covered benefits associated with Molina Dual Options?

A. The benefit package includes all benefits available through traditional Medicare and Medicaid programs, including long-term services and support (LTSS) and behavioral health.

Q. How is "existing plan of care" defined and interpreted by both Medicaid and the MyCare Ohio plans?

A. Molina Healthcare has been instructed by ODM to interpret "existing plan of care" as "existing treatment plan." ODM has also clarified that treatment plans are reviewed and amended every 90 days. Thus, the current, active treatment plan at the time of enrollment, demonstrated by claims history, may be maintained for the extended transition period. Additional services or increases in service amount or scope may require PA by the plan.

Because every MyCare Ohio enrollee will have a Care Manager, providers should contact the plan to offer support in the assessment and care planning process. Plans will engage providers in the same way, and will include existing services in the care planning process.

Claims

Q. What are my claim submission options?

A. 1.) Submit paper claims directly to Molina Healthcare.

2.) Clearinghouse (Emdeon)

- Emdeon is an outside vendor contracted by Molina Healthcare.
- When submitting EDI Claims (via a clearinghouse) to Molina Healthcare, please use the following: payer ID 20149.
- EDI or electronic claims get processed faster than paper claims.

3.) Submit claims directly through the Provider Web Portal at www.MolinaHealthcare.com.

Q. Is there a specific clearinghouse providers need to use?

A. Emdeon is Molina Healthcare's preferred clearinghouse. However, providers can use any clearinghouse of their choosing. Note that fees may apply. When submitting EDI Claims (via a clearinghouse) to Molina Healthcare, please use the following: payer ID 20149.

Q. I am a waiver service provider and do not have an NPI. How should I bill my claims?

A. Atypical providers are required to use their Medicaid Identification Number given to them by the state of Ohio to take the place of the NPI. As long as the provider submits using the Medicaid ID number, the claims will NOT be rejected for missing information.

Q. How long do I have to send in a corrected claim? What about a claims reconsideration/appeal?

A. In-network providers have 120 days from the date of the original remittance advice to submit corrected claims or claims reconsideration. The completed corrected claim form and corrected claim may be mailed to the claims address below or submitted through Molina Healthcare's Provider Web Portal at www. MolinaHealthcare.com:

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

The claims reconsideration form and documentation can be submitted via fax to: (800) 499-3406 or mailed to:

Molina Healthcare
Attn: Provider Services
P.O. Box 349020
Columbus, Ohio 43234-9020

Q. How have Medicare crossover payments changed since the implementation of MyCare Ohio?

A. Medicare claims for MyCare Ohio patients no longer cross over from Medicare. There are requirements for MyCare Ohio plans' Medicaid secondary payment for out-of-network providers during the period prior to Medicare passive enrollment. These are documented in Appendix C of the MyCare Ohio Provider Agreement.

Q. Are claim payments to be a single, combined payment or will the provider receive separate payments for Medicare and Medicaid?

A. There will be two payments, but both are combined on the same check. The remit will be broken out by Medicare and Medicaid for ease in posting.

Q. How long after a claim has been submitted can I expect payment?

A. In accordance with 42 C.F.R. § 447.46, Molina Healthcare must pay 90 percent of all submitted clean claims within 30 days of the date of receipt and 99 percent of such claims within 90 days of the date of receipt. Typically, you will receive payment within 30 days.

Q. Do you offer Electronic Funds Transfer (EFT) and Remittance Advice (ERA)?

A. Molina Healthcare has partnered with our payment vendor, FIS ProviderNet, for EFT and ERA. Access to the ProviderNet portal is FREE to our participating providers, and we encourage you to register after receiving your first check from Molina Healthcare.

If you have questions regarding the actual registration process, please contact ProviderNet at: (877) 389-1160 or email: Provider.Services@fisglobal.com.

Prior Authorizations (PA)

Q. What clinical guidelines does Molina Healthcare use or do you expect providers to use?

A. InterQual® medical necessity criteria is used to review the provided clinical information. The Molina Healthcare psychiatrist may also contact the behavioral health provider for a peer-to-peer discussion of the patient behavioral health needs.

Q. What services require a PA? Is it the same as the Medicaid PA list?

A. The same PA list that is used for Medicaid services is used for the Molina Dual Options plan, with the exception of an extended list for behavioral health, nursing facilities and waiver services. The Service Request Form and list of CPT Codes Requiring Prior Authorization can be found at www.MolinaHealthcare.com.

Q. How can I submit a PA request?

A. Providers should send requests for PAs to the Utilization Management department using the Service Request Form, which is available at www.MolinaHealthcare.com.

Service Request Forms may be faxed to the Utilization Management department at (877) 708-2166 or submitted via Molina Healthcare's Provider Web Portal.

Q. When should I send a PA and what should be included with it?

A. PA should be requested with supporting clinical documentation at least 14 business days prior to the date of the requested service. When the request is for an emergent service, Molina Healthcare should receive the request and clinical documentation within three business days of the qualifying event.

Information generally required to support decision making includes:

- Current (up to six months), adequate patient history related to the requested services
- Copy of current and existing treatment plan that identifies all services (Medical and Behavioral Health)
- Physical examination that addresses the problem
- Lab or radiology results to support the request (including previous MRI, CT, lab or x-ray report/results)
- Primary care provider (PCP) or specialist progress notes or consultations and any other information or data specific to the request

Q. What if it is an emergency service? Do I still need to send a PA?

A. PAs are not required for the following services: emergency and post-stabilization services including emergency behavioral health care, urgent care crisis stabilization including mental health, urgent support for home and community services, family planning services, preventive services, basic OB/prenatal care, communicable disease services including STI and HIV testing, and out-of-area renal dialysis.

Q. Do I need PA during the TOC period?

A. You only need PA for new services during the patient's 365-day TOC period. You do not need PA for services the patient was already using prior to enrolling in MyCare Ohio. You may need to provide original script, 485, CMN, etc., to show proof the service was already approved. However, they will not be reviewed for medical necessity.

Long-Term Services (LTSS)

Q. For which waiver services are members eligible?

A. Once the transition is complete and patients are assessed by Molina Dual Options' Care Management team, they may be eligible for other waiver services due to medical needs. These waiver services are benefits under what is now called the MyCare Ohio Waiver.

Q. What services are included in the Molina Dual Options MyCare Ohio Waiver?

A. The following services will all be included in the Molina Dual Options MyCare Ohio Waiver:

- **Adult day health**
- **Alternative meals service**
- **Assisted living service**
- **Choices - home care attendant service**
- **Chore services**
- **Community transition service**
- **Emergency response**
- **Enhanced community living service**
- **Home care attendant**
- **Home delivered meals**
- **Homemaker**
- **Home medical equipment and supplemental adaptive & assistive device services**
- **Maintenance and repair**
- **Independent living assistance**
- **Nutritional consultation**
- **Out-of-home respite**
- **Personal care**
- **Pest control**
- **Social work counseling**
- **Waiver nursing service**

Q. Which waiver services require PA?

A. All waiver services require PA.

Q. Which diagnosis (DX) code should be billed when one is not available?

A. The default ICD-9 DX code is 780.99 and the default ICD-10 DX code is R69.89.

Q. Is the Area Agencies on Aging (AAAs) still the Waiver Service Coordinator?

A. Molina Healthcare is required to contract with the AAAs as an option for individuals over the age of 60 who are on the MyCare Ohio community-based services waiver. For members under the age of 60, Molina Healthcare will serve as the Waiver Service Coordinator.

Q. How is provider compliance oversight handled?

A. Structural Compliance Reviews (SCR) will be conducted by either Public Consulting Group (PCG) or the PASSPORT Administrative Agency (PAA). Providers must continue to follow the current conditions of participation and service specification requirements of the Medicaid waivers for which they are certified/approved. Molina Healthcare will review providers' documentation to verify that services authorized and paid for are actually provided.

Q. Is there a billing procedure code set for LTSS providers?

A. There is a billing guide located in the appendix of the LTSS Provider Manual that providers can reference for procedure codes and modifiers. Also, there is an LTSS Waiver Service Billing Guide available at www.MolinaHealthcare.com.

Behavioral Health

Q. What are the covered benefits for behavioral health (BH)?

A. The following benefits are available to Molina Dual Options patients and are a responsibility of the health plan:

- BH counseling – individual and group
- Community psychiatric support treatment – individual and group
- Crisis intervention
- Mental health assessment – physician and non-physician
- Partial hospitalization
- Pharmacological management

Q. What is the biggest change for BH providers?

A. The biggest change is who to bill. Your billing practices (CPT codes, who performs the services, etc.) did not change. What changed is which health plan you should bill. For instance, you now bill non-Medicare covered services to Molina Healthcare, not ODM.

For Medicare covered services, it depends on who is covering the patient's Medicare benefit. If the patient is a MyCare Ohio Medicaid Only member (opt-out), you will need to bill traditional Medicare or the patient's advantage plan, if applicable, followed by a bill to Molina Healthcare for the patient's secondary payment. If the patient is a Molina Dual Options member (opt-in), you will only need to bill Molina Healthcare once, and the claim will automatically process for both the Medicare and Medicaid payments.

Q. Which BH services require PA?

A. The PA requirement for out-patient BH services has been removed for 2015. Inpatient, residential treatment, partial hospitalization, day treatment, electroconvulsive therapy (ECT) and applied behavioral analysis for treatment of autism spectrum disorder will require PAs.

Q. Is there a change in the coordination of benefits process for MyCare Ohio members?

A. ODM and the Ohio Department of Mental Health & Addiction Services (ODMHAS) have committed to continued coverage of current professionals for the first year of each member's enrollment. After TOC, Medicare billing requirements will apply. Molina Healthcare is working with in-network behavioral and mental health providers to help them care for more Medicare-eligible plan members.

Q. Does Molina Healthcare require BH providers that are dually certified for mental health and alcohol and other drug (AOD) services to continue to bill for Medicaid services using separate Medicaid provider IDs (i.e. Medicaid provider type 84 and type 95)?

A. Currently, Molina Healthcare is not requiring separate Medicaid provider IDs to be billed on each claim. Instead, a separate NPI should be used to distinguish the services. The services will be differentiated by the CPT code and modifier used on the claim form.

Q. Are there same-day service limits under MyCare Ohio?

A. Benefit limits that apply to Medicaid BH services in traditional Medicaid will also apply in MyCare Ohio.

Q. Will providers need to continue the "round and roll" methodology? What is your expectation in regards to billing for "time-based" services?

A. Follow the unit increments based on the standard CPT/HCPCS coding rules. For 15-minute units,

continue to round to the nearest whole unit and for 60-minute units, round to the nearest tenth of a unit (six-minute increments). Medications should be billed in number of units dispensed.

Q. How does your system handle claims modifiers, especially telemedicine or interactive videoconferencing?

A. Our system is configured based on Medicare billing requirements for Medicare-covered services and Medicaid billing requirements for services not covered by Medicare. Required modifiers for BH differ for the type of service rendered. Community alcohol and drug treatment services require HA or HF modifier. Community mental health services require HE, GT, or HQ, depending on the rendered service.

Long-Term Care/Nursing Facilities

Q. How is the Preadmission Screening and Resident Review (PASRR) process handled?

A. The Preadmission Screening and Resident Review (PASRR) process will continue to be administered by one of the following: Area Agency on Aging, ODMHAS, or the Ohio Department of Developmental Disabilities.

Q. Are Skilled Nursing Facility (SNF) providers still using the Minimal Data Set (MDS) for MyCare Ohio members?

A. Yes.

Q. Is Molina Healthcare able to use its own skilled criteria?

A. Medicare and Medicaid requirements are relevant, as this is the criteria by which Molina Healthcare is evaluated in the case of an appeal. Medicare and Medicaid definitions of medical necessity must also be met.

Q. How should a MyCare Ohio resident be coded in Section A on the Minimal Data Set (MDS)?

A. The resident should be coded as if he or she was not enrolled in MyCare Ohio. For example, if the person has been in the facility for more than 100 days and would normally be on Medicaid Fee-for-Service, he or she should be coded as "Medicaid."

Q. Is the three-day hospital stay still a requirement for a skilled stay?

A. No. Molina Healthcare does not require a three-day hospital stay for Molina Dual Options patients. Providers must continue to follow either traditional Medicare guidelines or guidelines of the advantage plan, should the person be a Molina MyCare Ohio Medicaid patient.

Q. When benefits overlap, how is it determined what is a Medicaid service and what is a Medicare service?

A. The authorization process first reviews against Medicare criteria, then Medicaid criteria. This means any overlap would be considered a Medicare service. This is similar to the Medicare Advantage process.

Q. How often can a provider bill for services?

A. Molina Healthcare can accept electronic billing at any time. A provider should consider the impact patient liability changes could have on the claims when determining how often to bill. The general consensus is that NF providers should continue to bill monthly, since plans update their system with the latest eligibility information by the fifth day of each month.

Q. Does the per diem rate remain the same during the 42-month demonstration period, or does it change based on the same schedule that Medicaid followed?

A. The per diem rate is based on the same schedule Medicaid has followed, with anticipated changes twice per year.

Q. Who is responsible for collecting patient liability? How are communication of this amount and any changes handled?

A. ODM will submit the appropriate amount for members with patient liability to Molina Healthcare in the eligibility file submissions. The patient liability is reduced from the payment to the NF on a monthly basis. It is the responsibility of the NF to collect patient liability. Providers must use Box 54 to report patient liability. If the liability changes, providers can have claims adjusted retroactively by providing documentation, 9401 or COLA report, as long as it is verified by the file submitted to Molina Healthcare from ODM.

Q. Are bed-holds still required? At what reimbursement rate?

A. Bed-hold days are a covered benefit for MyCare Ohio members under the Medicaid portion only. According to section 5165.34 of the Ohio Revised Code, reimbursement for NF bed-hold days shall be paid as follows:

- 50 percent of the NF's per diem rate if the facility had an occupancy rate in the preceding calendar year exceeding 95 percent; or
- 18 percent of the NF's per diem rate if the facility had an occupancy rate in the preceding calendar year of 95 percent or less.

Reimbursement for NF bed-hold days shall be considered payment in full, and the NF provider shall not seek supplemental payment from the resident.

Q. Do therapy services require a PA?

A. PA is required if Part B services are being rendered. For members with a custodial level of care, costs incurred for physical therapy, occupational therapy, speech therapy, and audiology services provided by licensed therapists or therapy assistants are reimbursed through the NF per diem. Costs incurred for the services of a licensed psychologist are reimbursable through the NF per diem. No reimbursement for psychologist services shall be made to a provider other than the NF, or a community mental health center certified by ODMHAS. Because these services are reimbursed at the SNF per diem rate, they would not require a PA.

Separately reimbursable services such as dental, DME, lab and x-ray, hospice, and services rendered by a community mental health provider would require PA. Please note, emergency services do not require a PA.

Q. Who pays for services while Medicaid is pending?

A. Because the individual is not enrolled in Medicaid, he or she is not yet eligible for MyCare Ohio.

Thus, providers should follow the current Medicaid Fee-for-Service application process. Medicaid will cover under Fee-for-Service until the person is enrolled in MyCare Ohio and the plan begins coverage of services on the first of the month (or the second month) after the person selects a plan.

Q. Who pays for services during an appeal?

A. During MyCare Ohio enrollment, continuation of benefits applies per the current processes, when a timely request is made per Ohio Administrative Code (OAC) 5160-58-08.4 Appeals and Grievances for MyCare Ohio.

Pharmacy

Q. Is there a copay for Part D coverage?

A. No. Under the Molina Dual Options plan, the member does not have an out-of-pocket responsibility.

Q. What are the non-covered Medicare Part D drugs?

A. The following are non-covered drugs under Medicare Part D:

- Agents when used for anorexia, weight loss, or weight gain (when not medically necessary);
- Agents when used to promote fertility;
- Agents used for cosmetic purposes or hair growth;
- Agents used for symptomatic relief of cough or colds;

- Prescription vitamins and minerals, except those used for prenatal care and fluoride preparations;

- Non-prescription drugs, except those medications listed as part of Molina Dual Options' over-the-counter (OTC) monthly benefit as applicable and depending on the plan;

- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale;

- Molina Dual Options patients may have a limited selection of these excluded medications as part of Medicaid coverage.

Q. Does Molina Healthcare have any step therapy restrictions?

A. Yes. In some cases, the Molina Dual Options plan requires patients to first try certain drugs to treat a medical condition before covering another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, the plan may not cover Drug B unless Drug A has first proven ineffective.

Q. Do I need to look at both the Medicare and Medicaid formulary?

A. For Molina Dual Options patients, use the Molina Dual Options Drug Formulary at www.MolinaHealthcare.com.

For Molina MyCare Ohio Medicaid patients, consult the formulary of the member's Medicare plan for Part D. You can also use the Molina Dual Options Drug Formulary to find Medicaid-covered items. Items marked with an asterisk are non-Part D drugs or over-the-counter items that are covered by Medicaid.

Q. What if a patient needs a drug and it is not on the Molina Healthcare Formulary?

A. Molina Healthcare accepts requests from providers or a pharmacy on behalf of the patient either by a written or verbal request. The request may be communicated through the standardized Medication Prior Authorization Request Form, or via fax or telephone. All requests will then be determined and the decision will be communicated to the member and his or her prescribing provider with an approval or denial decision within 72 hours or three calendar days after Molina Healthcare receives the completed request.