# Molina Dual Options MyCare Ohio

Regional Molina MyCare Ohio Forum

MOLINA HEALTHCARE

Your Extended Family.

# The Molina Mission

## Vision Statement

Molina Healthcare is an innovative national health care leader, providing quality care and accessible services in an efficient and caring manner.

## Mission Statement

Our mission is to provide quality health services to financially vulnerable families and individuals covered by government programs.

## Core Values

*We strive to be an exemplary organization.*

- We care about the people we serve and advocate on their behalf.
- We provide quality service and remove barriers to health services.
- We are health care innovators and embrace change quickly.
- We respect each other and value ethical business practices.
- We are careful in the management of our financial resources and serve as prudent stewards of the public's funds.

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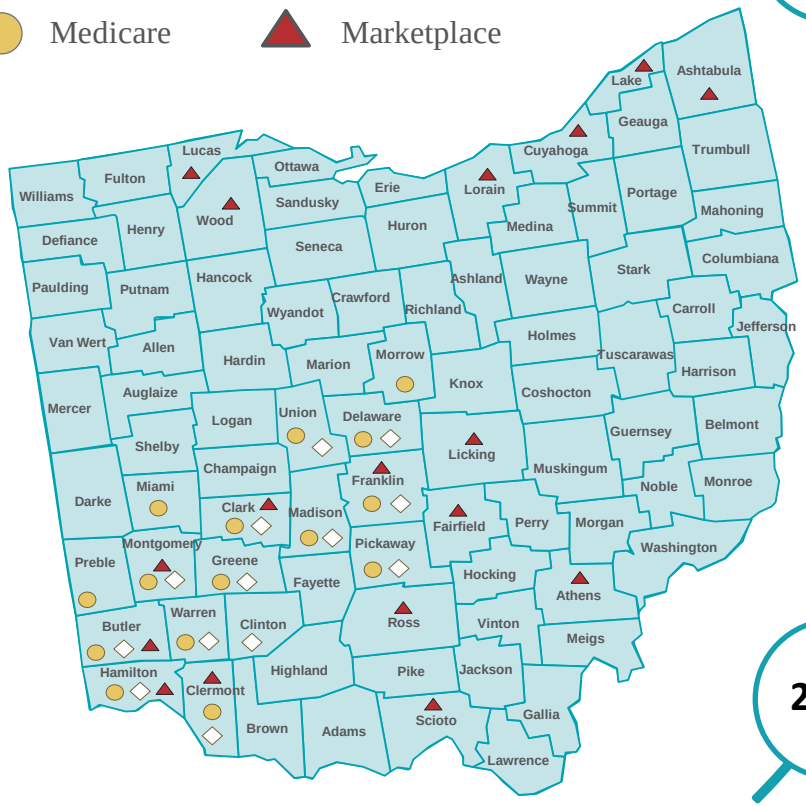
# Molina Healthcare of Ohio

## *Serving since 2005*

Medicaid
MyCare Ohio
Medicare
Marketplace




**2005** Began serving Ohio's **Covered Families and Children** Medicaid population

**2007** Began serving Ohio's **Aged, Blind or Disabled** Medicaid population

**2008** Awarded contract from Centers for Medicare and Medicaid Services to serve **Medicare** population

**2013** Began offering **Medicaid services statewide** and for Children with Special Health Care Needs

**2014** Began serving members through the **Health Insurance Marketplace**; Expanded service to Medicaid **Adult Extension Population** (childless adults and parents up to 138% FPL); Began serving beneficiaries eligible for both Medicaid and Medicare as part of **MyCare Ohio**.

### MHO Snapshot

**Membership:** 337K
**Employees:** 944
**Statewide MHO Offices:** 3

### Provider Network

**PCP/Specialists:** 25K
**Hospitals:** 215
**Ancillary Services:** 5,782

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# Three Decades of Delivering Access to Quality Care

Molina Healthcare has evolved over the years, but the mission has remained the same—providing those most in need with access to high quality health care services. It is our story that makes us proud to call ourselves an extended family, to the members, partners and communities we serve.

## 1980
FIRST PATIENT

**Molina Healthcare is born.** Originally named Molina Medical Centers, our primary care clinics begin serving communities in southern California.


## 1994
100,000 MEMBERS

Molina Healthcare establishes its first licensed health plan in **California**.

## 1997
110,000 MEMBERS

Molina Healthcare begins serving communities in **Utah**.

Molina Healthcare begins serving communities in **Michigan**.

## 2000
250,000 MEMBERS

Molina Healthcare begins serving communities in **Washington**.

## 2003
500,000 MEMBERS

Molina Healthcare becomes a **publicly-traded company** and is listed on the New York Stock Exchange as MOH.

## 2004
750,000 MEMBERS

Molina Healthcare begins serving communities in **New Mexico**.

## 2005
900,000 MEMBERS

Molina Healthcare begins serving communities in **Texas**.

Molina Healthcare begins serving communities in **Ohio**.

## 2006
1 MILLION MEMBERS

Molina Healthcare begins offering services to people with **Medicare.**

## 2008
1.25 MILLION MEMBERS

Molina Healthcare begins operating Fairfax County clinics in **Virginia.**

Molina Healthcare begins serving communities in **Florida**.

## 2010
1.6 MILLION MEMBERS

Molina Healthcare begins offering services through **Molina Medicaid Solutions.**

Molina Healthcare begins serving communities in **Wisconsin**.

## 2011
1.7 MILLION MEMBERS

Molina Medicaid Solutions' system in **Maine** receives full federal certification.

## 2012
1.8 MILLION MEMBERS

Molina Healthcare is awarded dual eligible contracts in **California, Illinois and Ohio**.

Molina Healthcare is named a **FORTUNE 500** company.

Molina Medicaid Solutions' system in **Idaho** receives full federal certification.

## 2014

Molina Healthcare begins serving communities in **South Carolina**.

Molina Healthcare begins serving dual eligible populations in California, Illinois and Ohio.

Molina Healthcare begins offering services through the **Health Insurance Marketplace**

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*Member numbers are approximate.*

40413UT0414

# My Care Ohio Eligibility

**Molina Dual Options MyCare Ohio** is the name of Molina Healthcare's Medicare-Medicaid Plan (MMP) and is an option for consumers in the **Central**, **West Central**, and **Southwest** regions.

- **Central:** Franklin, Madison, Union, Delaware, and Pickaway
- **West Central:** Greene, Clark, and Montgomery
- **Southwest:** Butler, Warren, Clinton, Clermont, and Hamilton

Consumers are eligible to join a MyCare Ohio managed care plan if:

- They are receiving full benefits from both Medicare and Medicaid
- They are 18 years of age or older
- They reside in a MyCare Ohio service region


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# Ohio MyCare Enrollment

## Medicare Passive Enrollment

In 2014, members were only asked to choose or were passively enrolled into a MyCare Ohio plan to administer their Medicaid benefits. Effective Jan. 1, 2015, any member who did not actively choose to NOT participate in their MyCare Ohio plan for their Medicare benefits was passively enrolled. This means the plan assigned to members for their Medicaid benefits in 2014 is now also the plan administering their Medicare benefits.

Members still have the right to opt-in or opt-out of the Medicare portion on a monthly basis. They will not have the option to opt-out of the Medicaid portion of MyCare Ohio.

Members who wish to opt-out of the Medicare portion must call the Ohio Medicaid Consumer Hotline at (800) 324-8680 or for hearing impaired TTY (800) 292-3572.

Any member who is newly eligible for MyCare Ohio after Jan. 1, 2015 who does not choose a plan will be automatically enrolled into one of the managed care plans for both their Medicaid and Medicare benefits.

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# Ohio MyCare Enrollment

## Medicare Passive Enrollment

**What are the benefits of having one plan for both Medicare and Medicaid from Molina Healthcare?**

The benefits of receiving Medicare and Medicaid from Molina Healthcare include:

- One ID card
- One point of contact to help you manage all of a member's health needs and assist in benefit explanation for both the Medicare and Medicaid benefits
- 24-Hour Nurse Advice Line and Behavioral Health Crisis Line
- Providers will only need to submit a single claim and it will be processed automatically under both the Medicare benefit and the Medicaid benefit.
- Providers will be able to speak to a single care manager regarding the care of the member.
- Molina Healthcare also offers value added benefits. For 2015, Molina Dual Options members will be eligible for:
  - Supplemental transportation benefit (60 one-way trips)
  - $20 per month allowance for over-the-counter items
  - $0 copays on generic prescriptions

**Will the MyCare Ohio benefits be different than traditional Medicare?**

For Molina Dual Options members, Molina Healthcare will offer at minimum the same benefits as traditional Medicare Part A, Part B and Part D benefits. Molina Healthcare's prior authorization (PA) policies may be different from the Centers for Medicare and Medicaid Services (CMS) or the Ohio Department of Medicaid (ODM). Providers should review these PA rules before providing services to Molina Dual Options members.

# Ohio MyCare Enrollment

**Passive Enrollment Split Billing**

Any member who changed from Medicaid Only (opt-out) to a full Medicare-Medicaid (opt-in) member with Molina Healthcare was given a new member ID number. If the member was passively enrolled, all claims with dates of service from Jan. 1, 2015 and after will need to be billed with the new member ID. All claims with a date of service prior to Jan. 1, 2015 will need to be billed with the member's Medicaid ID number.

A claim cannot include a date range with both 2014 and 2015 dates of service if the member's ID number changed. Providers will need to bill two separate claims splitting the dates of service. This will hold true any time a member changes Medicare plans and receives a new member ID.

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# Claims Processing

| Region | Counties | Implementation date | Number of claims | Total Payments made | % of denied claims | % of claims paid within 30 days |
|---|---|---|---|---|---|---|
| Central | Franklin, Union, Delaware, Madison, Pickaway | July 1, 2014 | 167,628 | $56,929,360.11 | 13.04% | 97.12% |
| Southwest | Butler, Warren, Clinton, Hamilton, Clermont | June 1, 2014 | 172,547 | $81,640,463.96 | 11.98% | 96.21% |
| West Central | Montgomery Clarke, Greene | July 1, 2014 | 108,904 | $33,048,705.67 | 13.44% | 96.78% |

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As of 1/26/2015

# Member Benefits

Molina Dual Options provides members with full Medicare Part A, Part B, and Part D as well as full Ohio Medicaid benefits. This includes, but is not limited to, the services listed here.

- In-patient Services
- Out-patient Services
- Rural Health Clinics (RHCS) and Federally Qualified Health Centers (FQHC)
- Physician Service (in office, home, hospital or elsewhere)
- Laboratory and X-Ray Services
- Family Planning Services and Supplies
- Home Health and Private Duty Nursing Services
- Podiatry
- Chiropractic Services
- DME
- Dental Services
- Vision Services
- Ambulance and Ambulette Services
- Nursing Facility Services
- Behavioral Health Services
- Home and Community-Based Waiver Services

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# Behavioral Health

**Molina Dual Options Behavioral Health Services** may be billed by providers certified by the Department of Mental Health (ODMH) (PT 84) and Ohio Department of Mental Health & Addiction Services (ODMHAS) (PT 95)

| Alcohol and other Drug Treatment Service | HCPCS/CPT Code | Required Modifier | Billing Increment | Reportable In |
|---|---|---|---|---|
| Ambulatory Detoxification | H0014 | HA or HF | Day | Whole Unit |
| Assessment | H0001 | HA or HF | Six Minutes | .1, .2, etc. |
| Case Management | H0006 | HA or HF | Six Minutes | .1, .2, etc. |
| Crisis Intervention | H0007 | HA or HF | Six Minutes | .1, .2, etc. |
| Group Counseling | H0005 | HA or HF | 15 Minutes | Whole Unit |
| Individual Counseling | H0004 | HA or HF | 15 Minutes | Whole Unit |
| Intensive Outpatient | H0015 | HA or HF | Day | Whole Unit |
| Laboratory Urinalysis | H0003 | HA or HF | Screen | Whole Unit |
| Medical/Somatic | H0016 | HA or HF | Six Minutes | .1, .2, etc. |
| Methadone Administration | H0020 | HA or HF | Dose | Whole Unit |

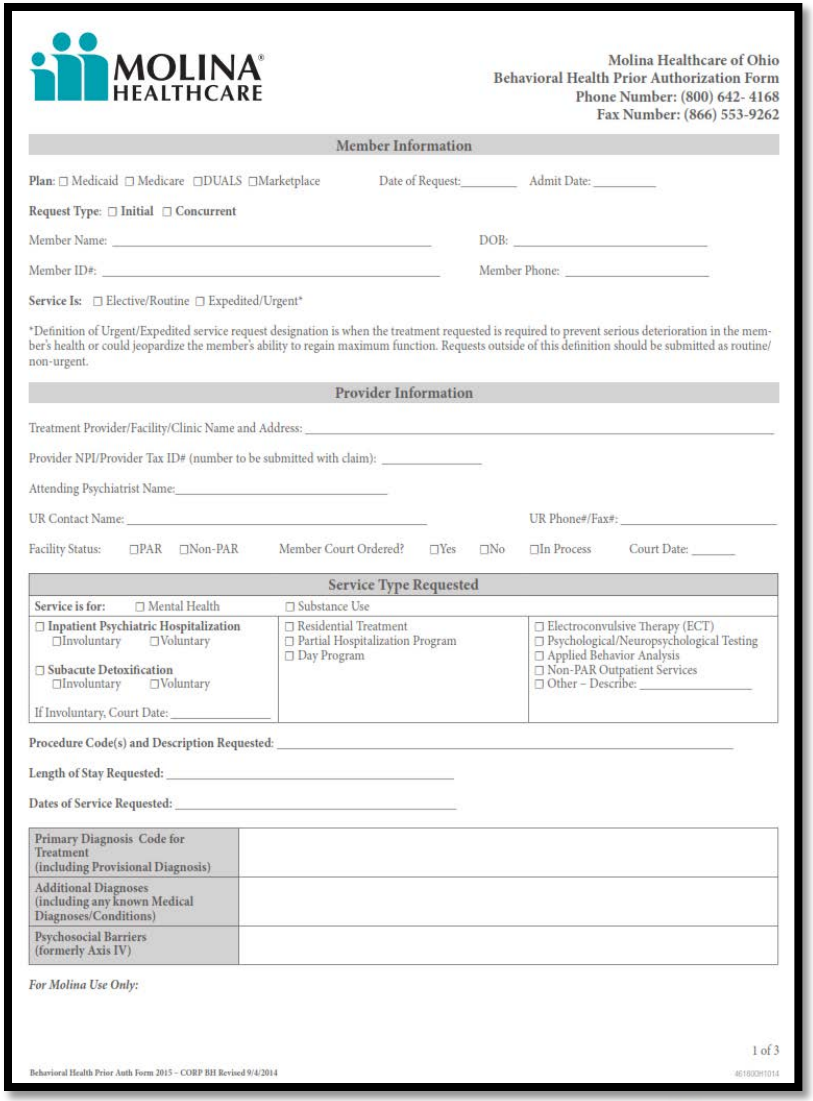
| Mental Health Service | HCPCS/CPT Code | Required Modifier | Billing Increment | Reportable In |
|---|---|---|---|---|
| BH Counseling-Group | H0004 | HQ | 15 Minutes | Whole Unit |
| BH Counseling-Individual | H0004 | HE or GT | 15 Minutes | Whole Unit |
| CPST-Group | H0036 | HQ | 15 Minutes | Whole Unit |
| CPST-Individual | H0036 | HE or GT | 15 Minutes | Whole Unit |
| Crisis Intervention | S9484 | HE | Six Minutes | .1, .2, etc. |
| Mental Health Assessment | H0031 | HE or GT | Six Minutes | .1, .2, etc. |
| Partial Hospitalization | S0201 | HE | Day | Whole Unit |
| Pharmacological Management | 90863 | HE, HQ or GT | Six Minutes | .1, .2, etc. |
| Psychiatric Diagnostic Interview | 90792 | HE or GT | Six Minutes | .1, .2, etc. |

# Behavioral Health Prior Authorizations

Most out-patient behavioral health services will not require a PA for 2015. Behavioral health services that do require a PA will be:

- Inpatient, residential treatment, partial hospitalization, day treatment
- Electroconvulsive therapy (ECT)
- Applied behavioral analysis (ABA) – for treatment of autism spectrum disorder (ASD)

Providers will need to fill out the Behavioral Health Outpatient Treatment Form and include the appropriate clinical information. The form is available online at www.MolinaHealthcare.com.



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Molina Healthcare of Ohio
Behavioral Health Prior Authorization Form
Phone Number: (800) 642- 4168
Fax Number: (866) 553-9262

**Member Information**

**Plan:** ☐ Medicaid ☐ Medicare ☐DUALS ☐Marketplace Date of Request:_____ Admit Date: _____

**Request Type:** ☐ **Initial** ☐ **Concurrent**

Member Name: _____ DOB: _____

Member ID#: _____ Member Phone: _____

**Service Is:** ☐ Elective/Routine ☐ Expedited/Urgent*

*Definition of Urgent/Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.

**Provider Information**

Treatment Provider/Facility/Clinic Name and Address: _____

Provider NPI/Provider Tax ID# (number to be submitted with claim): _____

Attending Psychiatrist Name:_____

UR Contact Name: _____ UR Phone#/Fax#: _____

Facility Status: ☐PAR ☐Non-PAR Member Court Ordered? ☐Yes ☐No ☐In Process Court Date: _____

**Service Type Requested**

**Service is for:** ☐ Mental Health ☐ Substance Use

| | | |
|---|---|---|
| ☐ **Inpatient Psychiatric Hospitalization** ☐Involuntary ☐Voluntary<br>☐ **Subacute Detoxification** ☐Involuntary ☐Voluntary<br>If Involuntary, Court Date: _____ | ☐ Residential Treatment<br>☐ Partial Hospitalization Program<br>☐ Day Program | ☐ Electroconvulsive Therapy (ECT)<br>☐ Psychological/Neuropsychological Testing<br>☐ Applied Behavior Analysis<br>☐ Non-PAR Outpatient Services<br>☐ Other – Describe: _____ |

**Procedure Code(s) and Description Requested:** _____

**Length of Stay Requested:** _____

**Dates of Service Requested:** _____

| | |
|---|---|
| Primary Diagnosis Code for Treatment (including Provisional Diagnosis) | |
| Additional Diagnoses (including any known Medical Diagnoses/Conditions) | |
| Psychosocial Barriers (formerly Axis IV) | |

***For Molina Use Only:***

1 of 3

Behavioral Health Prior Auth Form 2015 - CORP BH Revised 9/4/2014

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# HCBS Waivers

**Assisted Living Waiver Program –** Medicaid-eligible individuals age 21 and older who require at least an intermediate level of care, are in a nursing facility, and are enrolled in PASSPORT, Choices, Ohio Home Care Waiver, or Transition Carve-Out Waivers.

**Choices Program Waiver** – Medicaid-eligible individuals who are age 60 and older who require at least an intermediate level of care and live in an approved service area.

**Home and Community-Based Services Waivers** – Medicaid-eligible individuals who would otherwise need to be in a nursing home, hospital, or facility for the mentally retarded and/or developmentally disabled.

**Home Choice** – Medicaid-eligible individuals living in a facility-based care setting for at least 90 days and moving into qualified housing.

**Transitions II Aging Carve-Out –** Waivers-eligible individuals age 60 or older with either intermediate level of care or skilled per the Ohio Administrative Code (OAC).

**Ohio Home Care Waiver Program** – Medicaid-eligible individuals who are younger than age 59 who require an intermediate or skilled level of care.

**PASSPORT Waiver Program** – Medicaid-eligible individuals who are age 60 or older, and require at least an intermediate level of care.

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# Waiver Coordinator and Care Management

| Council on Aging (COA) of Southwestern Ohio | Central Ohio Area Agency on Aging | Area Agency on Aging PSA2 | National Church Residence (NCR) | Assisted Care by Blackstone | Molina Healthcare |
|---|---|---|---|---|---|
| Southwest Region | Central Region | West Central Region | Central Region | Southwest, Central, West Central | Southwest, Central, West Central |
| Waiver Service Coordinator for members age 60 and over.<br><br>Molina Healthcare will be the Waiver Service Coordinator for members under 60. | Waiver Service Coordinator for members age 60 and over.<br><br>Molina Healthcare will be the Waiver Service Coordinator for members under 60. | Waiver Service Coordinator for members age 60 and over.<br><br>Molina Healthcare will be the Waiver Service Coordinator for members under 60. | Members who reside in permanent supportive housing managed by NCR may choose NCR as the waiver service coordinator in the Central Region. | Waiver Service Coordinator for members age 60 and over.<br><br>Molina Healthcare will be the Waiver Service Coordinator for members under 60. | Waiver Service Coordinator for members under the age of 60.<br><br>Molina Healthcare will be the Care Manager for all members with the exclusion of a member in a Health Home. |

# Care Management Contact Schedule

| Risk stratification level | Minimum contact schedule | |
|---|---|---|
| | First six months of enrollment in the risk stratification level (Note: Visit is an in-person contact.) | Month seven until conclusion of the demonstration (Note: Visit is an in-person contact) |
| Intensive | 0-1 month: Two visits. Maximum of 15 days between visits. | One visit each month. Maximum of 30 days between visits. |
| | 2-6 months: One visit each month. Maximum of 30 days between visits. | Telephonic contact as needed. |
| High | 0-1 month: Two visits. Maximum of 15 days between visits.<br>2-3 months: One visit per month. Maximum of 30 days between visits.<br>4-6 months: Two visits in 90 days. Maximum of 45 days between visits.<br>Telephonic contact as needed. | One visit every two months. Maximum of 60 days between visits.<br>Monthly telephonic contact. |
| Medium | 0-2 months: One visit.<br>3-6 months: Two visits. Maximum of 60 days between visits. Telephonic contact as needed. | One visit every three months. Maximum of 90 days between visits.<br>Monthly telephonic contact. |
| Low | 0-4 months: One visit.<br>5-6 months: One telephonic contact. | One visit every six months. Maximum of 180 days between visits.<br>Quarterly telephonic contact. |
| Monitoring | 0-6 months: One visit.<br>Telephonic contact as needed. | One visit per year.<br>Semi-annual phone contact. |

# Self-Directed Care Through Morning Star

Self-directed services allow participating individuals or their representatives decision-making authority and management over their waiver services.

Self-directed services give individuals and their families more flexibility, control and responsibility for managing all aspects of the individual's care. Under self-directed care, an individual is the "employer" and can hire and/or fire a provider for violations of his or her contract.

A Waiver Service Coordinator /Molina Care Manager will provide oversight to assist the individual with self-directed personal care. The individual also may choose an authorized representative to help with the day-to-day supervision of his or her service provider and to assist with employer-related tasks. A financial management agency, also known as a fiscal intermediary, will work with individuals to handle the taxes, payroll and worker's compensation responsibilities of being an employer.

All self-directed care will be managed through Morning Star.

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# 2015 Non-Emergent Transportation

## Logisticare:

**For distances greater than 30 miles one way**, Logisticare will provide the transportation to Molina Dual Options MyCare Ohio Medicare-Medicaid Plan members. Note: It is important to have your patient(s) call two days in advance of the appointment to schedule the transportation. One additional passenger or escort is allowed to accompany the member if there is space availability. Logisticare does not cover door-to-door transportation. If this level of service is required, please use the Molina MyCare Ohio Medicaid Benefit.

**2015 Value-Added Benefits:**
New for 2015: Members of Molina Dual Options MyCare Ohio will receive a supplemental transportation benefit of 60 one-way trips at no cost to the member. Members of Molina MyCare Ohio Medicaid do not receive this value added benefit.

**Logisticare**: (877) 659-8407; TTY (866) 288-3133
**Molina Dual Options Member Services:** (855) 665-4623
**Molina MyCare Ohio Medicaid Member Services**: (855) 687-7862

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# 2015 Non-Emergent Transportation

**Local County Department of Job and Family Services Non-Emergency Transportation (NET) program will need to be utilized by all members who qualify whether they are on a waiver, or not.**

If a waiver member is eligible for NET transportation, the member needs to use NET transportation through the county first, as waiver is always payer of last resort. If the member has not completed the application for NET transportation with the county, the Care Manager and Waiver Service Coordinators are to assist with getting the application completed for the member.

While the application for NET transportation is pending approval and the member requires transportation, the Care Managers and Waiver Service Coordinators are able to approve waiver transportation on a case-by-case basis until the NET application is approved.

Once the application is approved, the member must utilize NET transportation for all eligible rides. NET transportation applications are generally approved within one week of receiving the application at the county offices. If NET cannot meet our members' needs, Molina Healthcare may approve the waiver covered benefits. Members may not self-refer for waiver benefits. All waiver services must be approved through Molina Care Managers.

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# 2015 Non-Emergent Transportation

**Skilled Nursing Facility Transportation**
Molina Healthcare uses its contracted ambulance network and this transportation requires PA. If the facility uses a non-par company, they can direct this provider to call us for PA. If your current preferred vendor is non-par, you can direct them to the Non-par Contract Request Form at www.MolinaHealthcare.com.

**Covered services under state plan benefits for non-ambulatory members only: Ambulette/Wheelchair Transport**

- Billing Code – A0130 and S0209
- No PA required for contracted providers
- Provider to call Molina Healthcare participating ambulance provider to schedule transportation

**Ambulance/Non-wheelchair Transport**

- A0426, A0428, A0430, A0431
- PA required
- Provider to call Molina Healthcare participating ambulance provider to schedule transportation
- Ambulance providers call Molina Healthcare for PA
- Eligibility dependent upon meeting criteria specified in OAC 5160-15-03

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# 2015 Non-Emergent Transportation

**Waiver transportation:**
During the transition of care period, supplemental transportation will continue to be an inclusive benefit for members on the following waivers of origin:

- Transitions II Aging Carve-Out Waiver
- Ohio Home Care Waiver
- PASSPORT Waiver

When the transition of care period is over, all waiver eligible members will be enrolled in the MyCare Ohio combined waiver. At this point, waiver transportation will be determined on a case-by-case basis.

Waiver transportation will be included in the waiver service plan that is authorized by the Waiver Service Coordinator/Molina Care Manager. Transportation services must be provided by a transportation provider certified by the Ohio Department of Aging to render this waiver service.

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# Transition of Care (TOC)

| Transition Requirements | HCBS Waiver Beneficiaries | Non-Waiver Beneficiaries with LTC Needs (HH and PDN use) | NF Beneficiaries<br><br>AL Beneficiaries | Beneficiaries not identified for LTC Services |
|---|---|---|---|---|
| Physician | 90-day transition for individuals identified for high-risk care management; 365 days for all others | 90-day transition for individuals identified for high-risk care management; 365 days for all others | 90-day transition for individuals identified for high-risk care management; 365 days for all others | 90-day transition for individuals identified for high-risk care management; 365 days for all others |
| Dialysis Treatment | 90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider | 90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider | 90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider | 90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider |

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# Transition of Care (Home Health)

| Transition Requirements | HCBS Waiver Beneficiaries | Non-Waiver Beneficiaries with LTC Needs (HH and PDN use) | NF Beneficiaries<br><br>AL Beneficiaries | Beneficiaries not identified for LTC Services |
|---|---|---|---|---|
| Medicaid Home Health and PDN | Maintain service at current level and with current providers at current Medicaid reimbursement rates. Changes may not occur unless:<br><br>A significant change occurs as defined in OAC 5160-45-01; or<br><br>Individuals express a desire to self-direct services; or<br><br>After 365 days | Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation | For AL: Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation | N/A |

# Transition of Care (Waiver)

| Transition Requirements | HCBS Waiver Beneficiaries |
|---|---|
| Waiver Services – Direct Care<br>Personal Care<br>Waiver Nursing<br>Home Care Attendant<br>Choice Home Care Attendant<br>Out of Home Respite<br>Enhanced Community Living<br>Adult Day Health Services<br>Social Work Counseling<br>Independent Living Assistance | Maintain service at current level and with current providers at current Medicaid reimbursement rates. Plan initiated changes may not occur unless:<br>A significant change occurs as defined in OAC 5160-45-01 ; or<br>Individuals express a desire to self-direct services; or<br>After 365 days. |
| Waiver Services – All other | Maintain service at current level for 365 days and existing service provider at existing rate for 90 days. Plan initiated change in service provider can only occur after an in-home assessment and plan for the transition to a new provider. |

# Prior Authorizations (PA)

PA is a request for prospective review. It is designed to:

- Assist in benefit determination
- Prevent unanticipated denials of coverage
- Create a collaborative approach to determining the appropriate level of care for members receiving services
- Identify Care Management and Disease Management opportunities
- Improve coordination of care

Requests for services on the Molina Healthcare Prior Authorization Guide are evaluated by licensed nurses and trained staff that have authority to approve services.

Molina Healthcare will **not** retroactively approve PA services. All services must be requested prior to services being rendered.

# PA Timeline

Molina Healthcare recommends PAs be requested at least seven days prior to services being rendered.

Molina Medicare/Molina Dual Options Timeliness Standards

| UM decision needed | Decision time frame |
|---|---|
| Standard (non-expedited) pre-service determination | Within 14 calendar days of receipt of request |
| Urgent concurrent review | Within 24 hours of receipt of the request |
| Expedited initial determinations | Within 72 hours of receipt of request |
| Reopening of adverse determination (additional information received) | If meets CMS criteria (MCM Chapter 13 130.1) for reopening |

Molina Medicaid Timeliness Standards (services not covered by Medicare)

| UM decision needed | Decision time frame |
|---|---|
| Routine (non-expedited) pre-service determinations | Within 14 calendar days of receipt of request |
| Expedited/urgent determination | Within 72 hours of receipt of request |
| Urgent concurrent review | Within 24 hours of receipt of request |

# PA Timeline

**PA - Urgent vs. Standard**

Standards have been established by regulations to ensure a process for determining the urgency of a PA request for medical services. The CMS definition of an expedited PA request is when waiting the standard 14-day turnaround time would jeopardize a member's health or his or her ability to regain maximum function.

PA requests for medical services should be marked *Urgent* following the guidelines listed above. If the clinical information submitted does not support a request as being *Urgent*, the request will be processed as a *Standard* request and processed within 14 calendar days.

You can submit a PA by fax or by calling the Utilization Management (UM) department. For MyCare Ohio PA requests, please do not use the Molina E-portal.

When checking to see if a service requires a PA we **strongly recommend** first viewing the service request form, then proceeding to verify if the specific CPT code requires a PA or is a non-covered service. The most up-to-date version of these items can be found under the forms section of the Molina Healthcare provider website at www.MolinaHealthcare.com.

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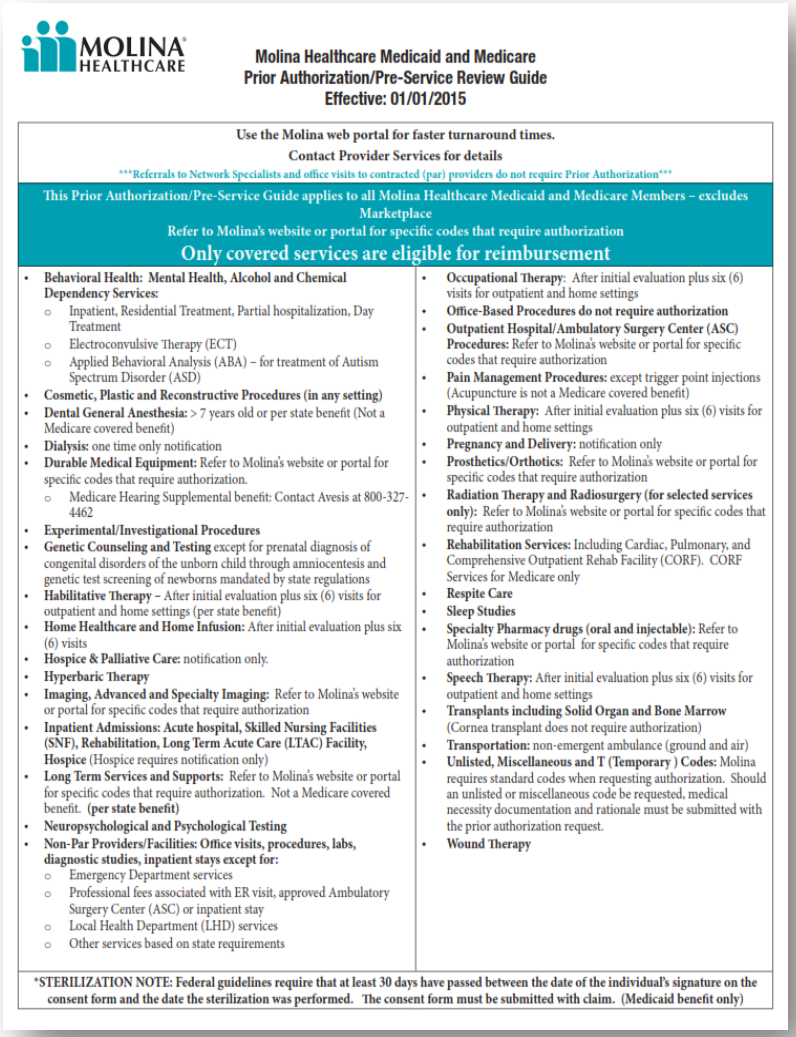
# Prior Authorizations



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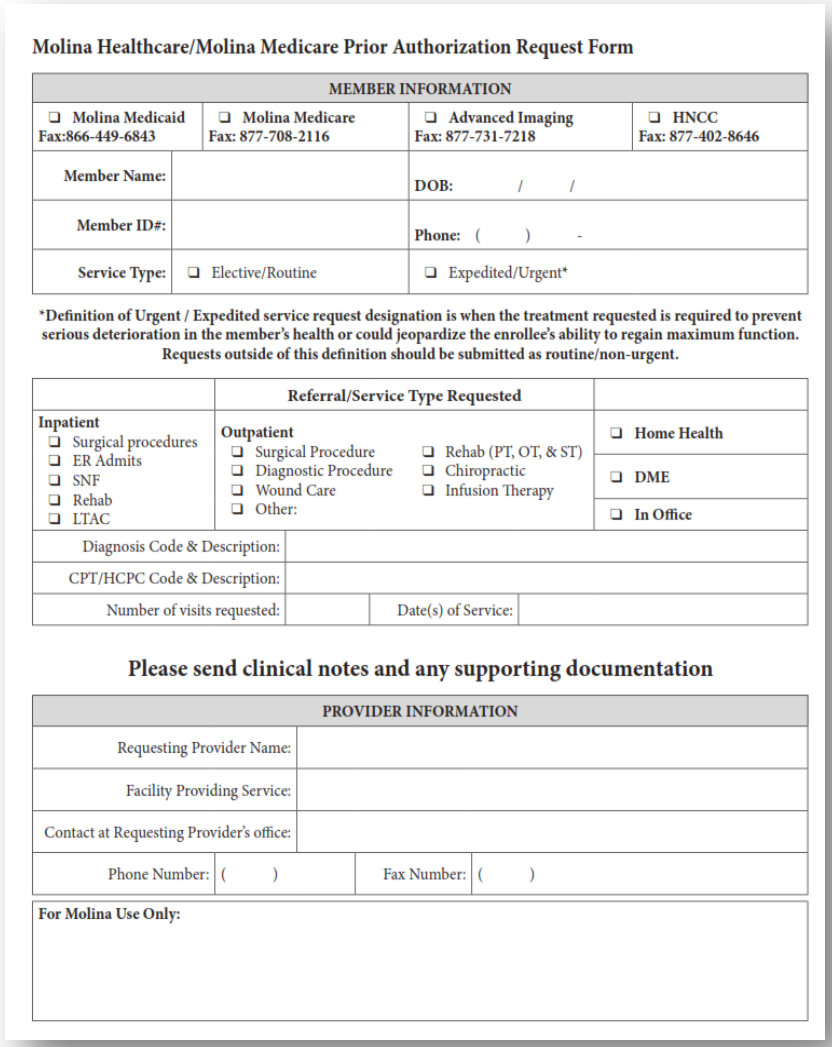
**Molina Healthcare Medicaid and Medicare**
**Prior Authorization/Pre-Service Review Guide**
**Effective: 01/01/2015**

**Use the Molina web portal for faster turnaround times.**
**Contact Provider Services for details**
***Referrals to Network Specialists and office visits to contracted (par) providers do not require Prior Authorization***

**This Prior Authorization/Pre-Service Guide applies to all Molina Healthcare Medicaid and Medicare Members – excludes Marketplace**
**Refer to Molina's website or portal for specific codes that require authorization**
**Only covered services are eligible for reimbursement**

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, Partial hospitalization, Day Treatment
  - Electroconvulsive Therapy (ECT)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD)
- **Cosmetic, Plastic and Reconstructive Procedures (in any setting)**
- **Dental General Anesthesia:** > 7 years old or per state benefit (Not a Medicare covered benefit)
- **Dialysis:** one time only notification
- **Durable Medical Equipment:** Refer to Molina's website or portal for specific codes that require authorization.
  - Medicare Hearing Supplemental benefit: Contact Avesis at 800-327-4462
- **Experimental/Investigational Procedures**
- **Genetic Counseling and Testing** except for prenatal diagnosis of congenital disorders of the unborn child through amniocentesis and genetic test screening of newborns mandated by state regulations
- **Habilitative Therapy** – After initial evaluation plus six (6) visits for outpatient and home settings (per state benefit)
- **Home Healthcare and Home Infusion:** After initial evaluation plus six (6) visits
- **Hospice & Palliative Care:** notification only.
- **Hyperbaric Therapy**
- **Imaging, Advanced and Specialty Imaging:** Refer to Molina's website or portal for specific codes that require authorization
- **Inpatient Admissions: Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility, Hospice** (Hospice requires notification only)
- **Long Term Services and Supports:** Refer to Molina's website or portal for specific codes that require authorization. Not a Medicare covered benefit. **(per state benefit)**
- **Neuropsychological and Psychological Testing**
- **Non-Par Providers/Facilities: Office visits, procedures, labs, diagnostic studies, inpatient stays except for:**
  - Emergency Department services
  - Professional fees associated with ER visit, approved Ambulatory Surgery Center (ASC) or inpatient stay
  - Local Health Department (LHD) services
  - Other services based on state requirements
- **Occupational Therapy**: After initial evaluation plus six (6) visits for outpatient and home settings
- **Office-Based Procedures do not require authorization**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:** Refer to Molina's website or portal for specific codes that require authorization
- **Pain Management Procedures:** except trigger point injections (Acupuncture is not a Medicare covered benefit)
- **Physical Therapy:** After initial evaluation plus six (6) visits for outpatient and home settings
- **Pregnancy and Delivery:** notification only
- **Prosthetics/Orthotics:** Refer to Molina's website or portal for specific codes that require authorization
- **Radiation Therapy and Radiosurgery (for selected services only):** Refer to Molina's website or portal for specific codes that require authorization
- **Rehabilitation Services:** Including Cardiac, Pulmonary, and Comprehensive Outpatient Rehab Facility (CORF). CORF Services for Medicare only
- **Respite Care**
- **Sleep Studies**
- **Specialty Pharmacy drugs (oral and injectable):** Refer to Molina's website or portal for specific codes that require authorization
- **Speech Therapy:** After initial evaluation plus six (6) visits for outpatient and home settings
- **Transplants including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization)
- **Transportation:** non-emergent ambulance (ground and air)
- **Unlisted, Miscellaneous and T (Temporary ) Codes:** Molina requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale must be submitted with the prior authorization request.
- **Wound Therapy**

*STERILIZATION NOTE: Federal guidelines require that at least 30 days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed. The consent form must be submitted with claim. (Medicaid benefit only)



**Molina Healthcare/Molina Medicare Prior Authorization Request Form**

| MEMBER INFORMATION | | | |
|---|---|---|---|
| ❑ Molina Medicaid Fax:866-449-6843 | ❑ Molina Medicare Fax: 877-708-2116 | ❑ Advanced Imaging Fax: 877-731-7218 | ❑ HNCC Fax: 877-402-8646 |
| Member Name: | | DOB: / / | |
| Member ID#: | | Phone: ( ) - | |
| Service Type: | ❑ Elective/Routine | ❑ Expedited/Urgent* | |

***Definition of Urgent / Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.**

| | Referral/Service Type Requested | |
|---|---|---|
| **Inpatient**<br>❑ Surgical procedures<br>❑ ER Admits<br>❑ SNF<br>❑ Rehab<br>❑ LTAC | **Outpatient**<br>❑ Surgical Procedure<br>❑ Diagnostic Procedure<br>❑ Wound Care<br>❑ Other:<br>❑ Rehab (PT, OT, & ST)<br>❑ Chiropractic<br>❑ Infusion Therapy | ❑ Home Health<br>❑ DME<br>❑ In Office |
| Diagnosis Code & Description: | | |
| CPT/HCPC Code & Description: | | |
| Number of visits requested: | Date(s) of Service: | |

**Please send clinical notes and any supporting documentation**

| PROVIDER INFORMATION | | | |
|---|---|---|---|
| Requesting Provider Name: | | | |
| Facility Providing Service: | | | |
| Contact at Requesting Provider's office: | | | |
| Phone Number: | ( ) | Fax Number: | ( ) |

**For Molina Use Only:**

*Please note: Molina Healthcare's PA requirements are different from ODM and CMS. Please check the pre-service request form and codified list to verify if a particular service requires a PA.

MOLINA HEALTHCARE

# Clinical Information

Information generally required to support authorization decision making includes:

- Current (up to six months) adequate patient history related to the requested services
- Relevant physical examination that addresses the problem
- Relevant lab or radiology results to support the request (including previous MRI, CT lab or X-ray report/results)
- Relevant specialty consultation notes
- Any other information or data specific to the request

Home health providers will need a current signed 485 and OASIS assessment. For a continuation of a certification period, Molina Healthcare will need the last two weeks of skilled nursing notes, aide notes, PT/OT notes, etc.

Durable Medical Equipment (DME) providers will require a prescription (Rx), certain procedural terminology codes (if using a miscellaneous code, we need a description), diagnosis codes, clinical notes supporting Certificate of Medical Necessity (CMN) (if applicable), home evaluation (if applicable), and invoice pricing.

MOLINA HEALTHCARE

# Nursing Facilities

**What is the process for Nursing Facility admission pre-certifications?**

The majority of pre-certifications will take place through the discharge planning process, when a member in need of post-acute nursing facility care is identified. Molina Healthcare's Care Review Clinicians will be in direct contact with the acute inpatient facilities, assisting with the discharge process and ensuring that medically necessary nursing facility admissions occur in a timely manner. These requests for nursing facility admissions are reviewed and a determination is rendered within 24 hours. In the event that a member is an emergent admit (i.e. direct admit from home or emergency room due to imminent safety risk) to a nursing facility after normal business hours, Molina Healthcare will accept notification from the nursing facility of the admission on the next business day. Please provide clinical information to support the admission.

**Who is responsible for calling in the request for the pre-certification?**

The Nursing Facility is responsible for contacting Molina Healthcare to get pre-certification. The hospital's discharge planner responsibility lies in working with Molina Healthcare to find a facility that will accept the member. The discharge planner needs to instruct the facility to call Molina Healthcare for the pre-certification.

# Nursing Facilities

| Care | Molina Dual Options member (Molina Healthcare administers both Medicare and Medicaid benefit) | Molina MyCare Ohio Medicaid member (opt-out; Molina Healthcare administers only the Medicaid benefit) | Molina Healthcare Contact Person |
|---|---|---|---|
| **Bed Hold Days** | • 30 days per calendar year under Medicaid benefit. No notification required. | • 30 days per calendar year under Medicaid benefit. No notification required. | N/A |
| **Hospice** | • Notification only. Medical necessity review is not required with physician's order.<br>• Medicaid covers facility room and board. | • Notification only. Medical necessity review is not required with physician's order.<br>• Medicaid covers facility room and board. | Assigned Utilization Management (UM) Care Review Clinician |
| **Readmit from acute hospital to skilled bed** | • Authorization required<br>• Three-day stay requirement waived | • Notification only. No authorization required until 100 skilled Medicare days have been exhausted. | Assigned UM Care Review Clinician |
| **Readmit from acute hospital to custodial bed** | • Notification only<br>• Authorizations entered for six-month periods | • Notification only<br>• Authorizations entered for six-month periods | Assigned Care Management (CM) Care Manager |
| **New admission - skilled** | • Authorization required. Three-day stay requirement waived.<br>• Authorizations entered for seven-day periods. | • Notification only. No authorization required until 100 skilled Medicare days have been exhausted.<br>• Authorizations entered for seven-day periods | Assigned UM Care Review Clinician |
| **New admission - custodial** | • Notification only with authorizations entered for six-month periods | • Notification only with authorizations entered for six-month periods | Assigned CM Care Manager |
| **Currently admitted - status changes from skilled to custodial** | • Notification only if member is previously established long-term placement.<br>• If long-term placement has not been established, must notify assigned Care Manager so that a level of care (LOC) assessment can be completed. Custodial authorization will be entered for one month pending LOC assessment. | • Notification only if member is previously established long-term placement.<br>• If long-term placement has not been established, must notify assigned Care Manager so that a level of care (LOC) assessment can be completed. Custodial authorization will be entered for one month pending LOC assessment. | Assigned UM Care Review Clinician / Assigned CM Care Manager (for non-LTC members) |
| **Currently admitted - status changes from custodial to skilled** | • Authorization required<br>• Authorizations entered for seven-day periods | • Notification only. No authorization required until 100 skilled Medicare days have been exhausted. | Assigned UM Care Review Clinician |

# Nursing Facilities

| Care | Molina Dual Options member (Molina Healthcare administers both Medicare and Medicaid benefit) | Molina MyCare Ohio Medicaid member (opt-out; Molina Healthcare administers only the Medicaid benefit) | Molina Healthcare Contact Person |
|---|---|---|---|
| **Ancillary/Support services not included in per diem (non-hospice)** | • Subject to Molina Healthcare's PA List (on website)<br>• Service provider will obtain PA directly from Molina Healthcare | • Medicare Primary Services - No PA with Molina Healthcare required. Molina Healthcare will adjudicate claims for secondary Medicaid benefit utilizing Medicare Explanation of Benefits (EOB) .<br>• Medicaid Primary Services – Refer to Molina Healthcare PA grid. | Assigned UM Care Review Clinician for Molina Dual Options member |
| **Therapies (physical, occupational and/or speech) to be billed under Medicare Part B** | • PA required after initial evaluation and six therapy sessions | • No PA with Molina Healthcare required. Molina Healthcare will adjudicate claims for secondary Medicaid benefit utilizing Medicare EOB if Part B therapy cap has been reached. | Assigned UM Care Review Clinician |
| **New enrollee in MyCare Ohio while in facility (either skilled or custodial)** | • Contact Molina Healthcare for PA/notification | • Contact Molina Healthcare for PA/notification | Assigned UM Care Review Clinician |

# Nursing Facility Patient Liability

**What to do if the patient liability taken out was incorrect**
Patient liability is calculated by the County Department of Job and Family Services (CDJFS) and entered into the ODM enrollment system. Molina Healthcare uses the enrollment files from the state as the source for patient liability and not the amount billed on the claim. Due to a lag from when patient liability is updated by the county and entered in to the ODM enrollment system, Molina Healthcare may not yet have the correct patient liability amount for a given month.

Nursing Facility and Hospice Providers
If the incorrect patient liability amount has been applied to a claim, send the approved 9401 form with the nursing facility patient liability claims reconsideration form available at www.MolinaHealthcare.com. Upon receipt, Molina Healthcare will update the member record with the revised patient liability amount and reprocess all associated claims.

**Please use the following addresses/fax numbers to submit the spreadsheet. *To comply with HIPAA, if you submit via email, you must use secure email.***

Email: MHOClaimsReconsideration@MolinaHealthcare.com
Fax: (800) 499-3406

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# Nursing Facility Patient Liability

**MyCare Ohio**
**Patient/Client Liability Reconciliation**

**Health Plan (check one)** **Date** _____

**Aetna** ___
**Buckeye** ___
**CareSource** ___
**Molina** ___
**United** ___

**Facility Name** _____ **Facility NPI** _____ **Facility Medicaid #** _____

**Contact Person** _____ **Email** _____

***You must attach documentation of patient/client liability (for example, 9401, notice from AAA) for each claim listed below.***
***Please use a separate form for each MyCare Ohio health plan.***

| **Claim #** *(Optional)* | **Check if Resubmission** *(9401 previously submitted)* | **Last Name** | **First Name** | **Health Plan Member ID** *(Aetna, CareSource, United only)* | **Patient's Medicaid #** | **Patient Liability Deducted from Paid Claim** | **Actual Patient Liability** *(supported by attached documentation)* |
|---|---|---|---|---|---|---|---|
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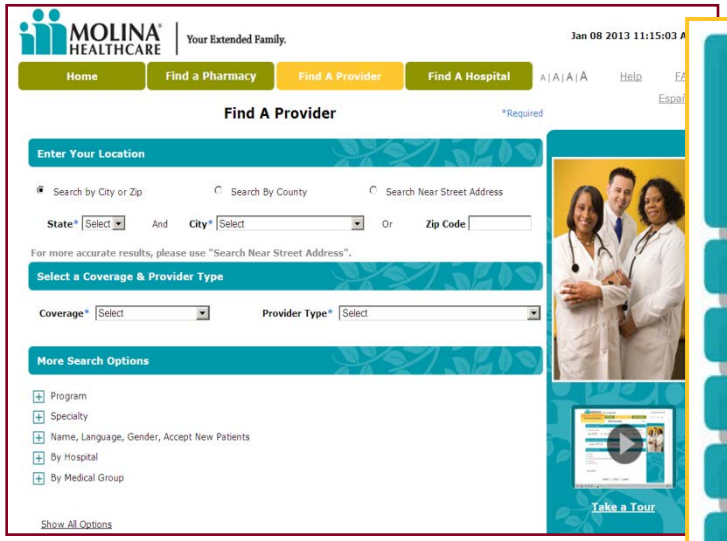
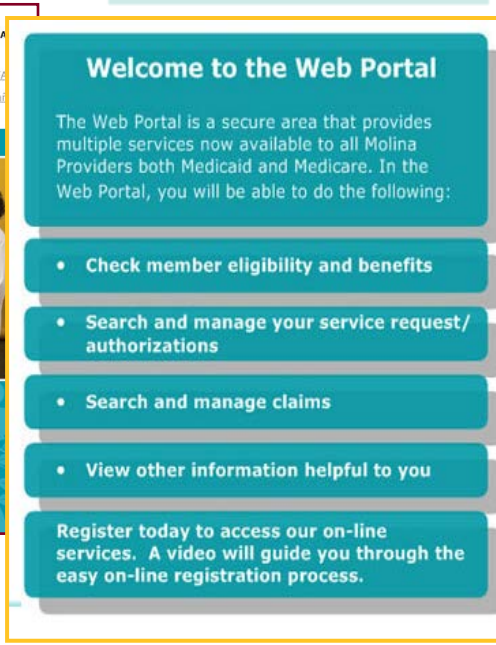
MOLINA HEALTHCARE

# Provider Online Resources

- Provider Manuals
- Provider Online Directories
- Web Portal
- Preventative & Clinical Care Guidelines
- Prior Authorization Information
- Advanced Directives
- Claims Information
- Pharmacy Information
- HIPAA
- Fraud Waste and Abuse Information
- Frequently Used Forms
- Communications & Newsletters
- Member Rights & Responsibilities
- Contact Information

# Electronic Funds Transfer & Remittance Advice

Molina Healthcare has partnered with our payment vendor, FIS ProviderNet, for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (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.

**New ProviderNet User Registration:**

1. Go to https://providernet.adminisource.com.
2. Click "Register."
3. Accept the Terms.
4. Verify your information

**BENEFITS**

- Administrative rights to sign-up/manage your own EFT Account
- Ability to associate new providers within your organization to receive EFT/835s
- View/print/save PDF versions of your Explanation of Payment (EOP)
- Historical EOP search by various methods (i.e. claim number, member name)
- Ability to route files to your File Transfer Protocol (FTP) and/or associated Clearinghouse

**If you are associated with a Clearinghouse:**

1. Go to "Connectivity" and click the "Clearinghouses" tab.
2. Select the Tax ID for which this clearinghouse applies.
3. Select a Clearinghouse (if applicable, enter your Trading Partner ID).
4. Select the file types you would like to send to this Clearinghouse and click "Save."

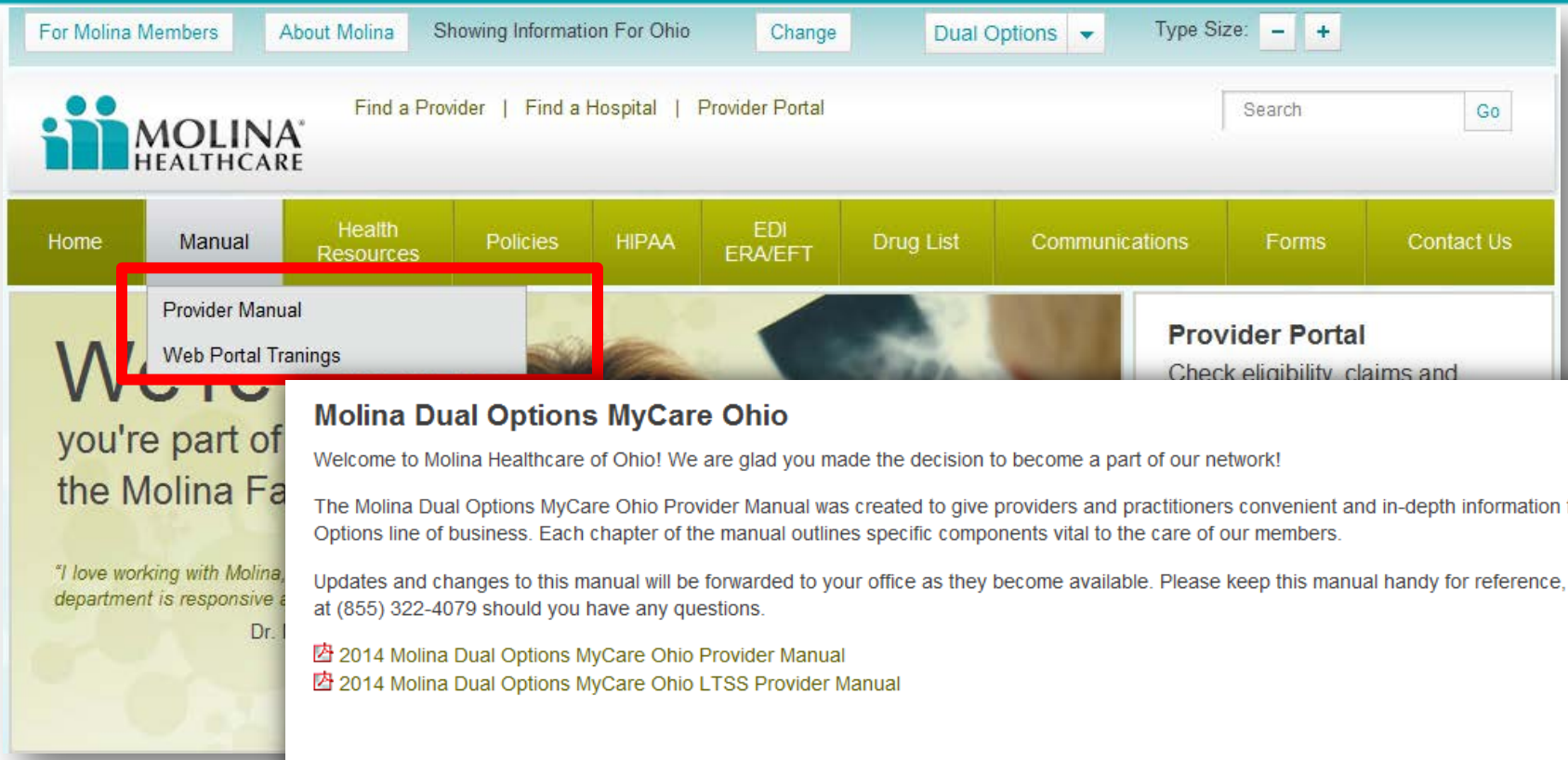
**If you are a registered ProviderNet user:**

1. Log in to ProviderNet and click "Provider Info."
2. Click "Add Payer" and select Molina Healthcare from the payers list.
3. Enter recent check number associated with your primary Tax ID and Molina Healthcare.

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

MOLINA HEALTHCARE

# Dual Options Provider Training Guides




## Molina Dual Options MyCare Ohio

Welcome to Molina Healthcare of Ohio! We are glad you made the decision to become a part of our network!

The Molina Dual Options MyCare Ohio Provider Manual was created to give providers and practitioners convenient and in-depth information for our Dual Options line of business. Each chapter of the manual outlines specific components vital to the care of our members.

Updates and changes to this manual will be forwarded to your office as they become available. Please keep this manual handy for reference, and contact us at (855) 322-4079 should you have any questions.

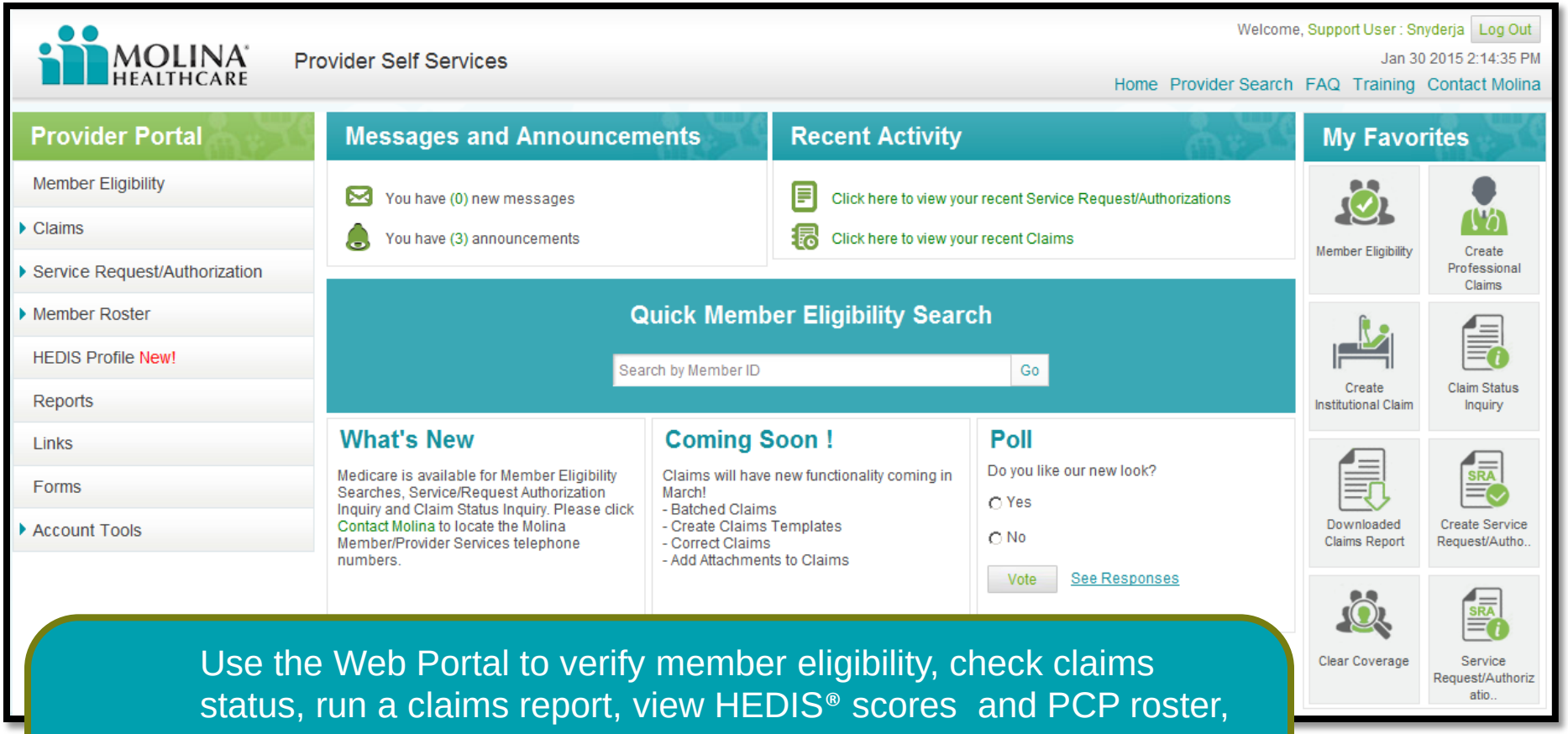
- 2014 Molina Dual Options MyCare Ohio Provider Manual
- 2014 Molina Dual Options MyCare Ohio LTSS Provider Manual

**Provider Orientation - Dual Options**

- Dual Options Orientation Presentation
- Long-Term Services and Supports Orientation Presentation
- Nursing Facilities Orientation Presentation
- Behavioral Health Orientation Presentation
- Disability Awareness & Sensitivity Training
- Claims Submission Training
- Transportation Training
- Frequently Asked Questions
- Patient Liability Training

Click here for Provider Forms.

# Web Portal




Use the Web Portal to verify member eligibility, check claims status, run a claims report, view HEDIS® scores and PCP roster, and submit and check status of PAs.

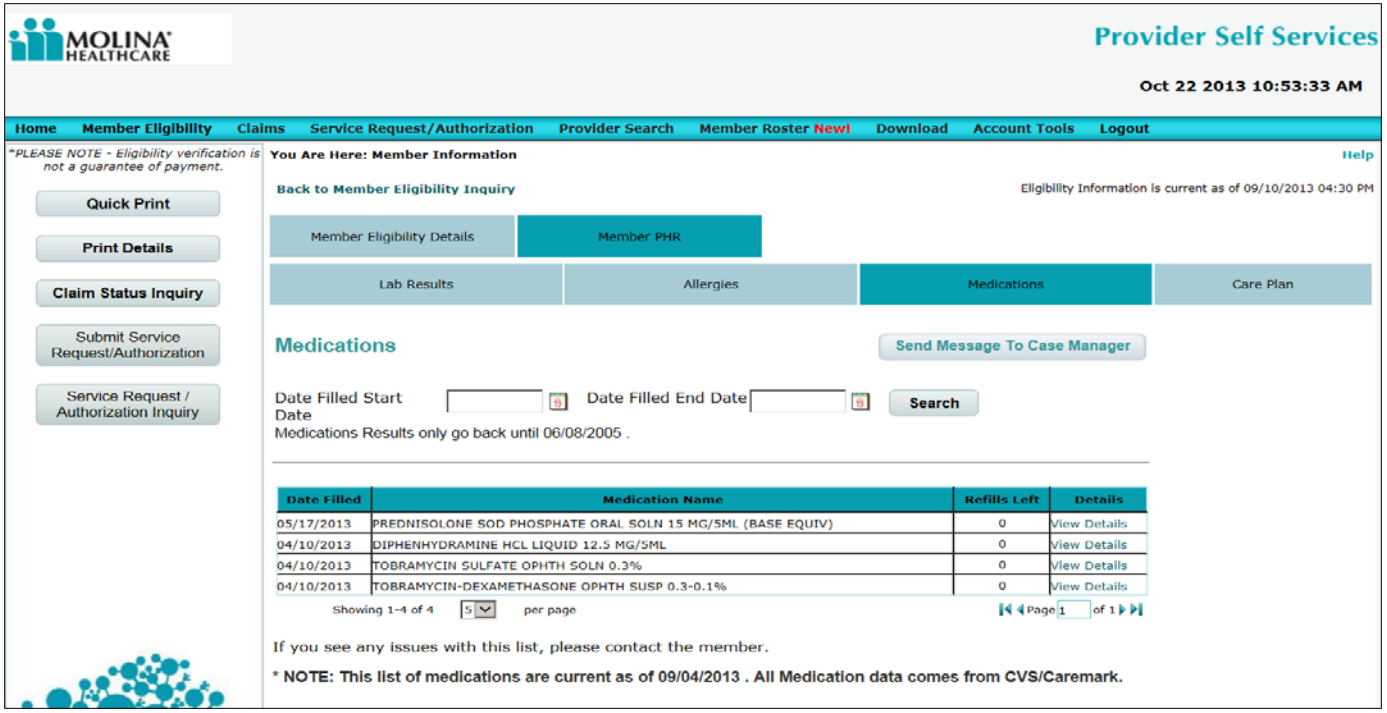
Web Portal:
**https://eportal.MolinaHealthcare.com/Provider/login**

MOLINA HEALTHCARE

# Secure Messaging with Care Management

- **Secure messaging** is a new functionality that allows providers and members to communicate with Care Managers regarding elements of the Personal Health Record (PHR) including lab results, medications, allergies, and care plan.

- Providers and members can send messages to the Care Manager via Web Portal. Care Managers respond to the messages via Microsoft Outlook email notification using new Customer Relationship Management (CRM) functionality.




MOLINA HEALTHCARE

# Claims

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.

The clean pharmacy and non-pharmacy claims will be separately measured against the 30- and 90-day prompt pay standards. The prompt pay requirement applies to the processing of both electronic and paper claims for contracting and non-contracting providers by Molina Healthcare and delegated claims processing entities.

These standards have to be met in order for Molina Healthcare to remain compliant with state requirements and ensure providers are paid timely.

# Claims

**Claims Submission Options**

1. Submit paper claims directly to Molina Healthcare.
2. Clearinghouse (Emdeon)
   - Emdeon is an outside vendor that is used by Molina Healthcare.
   - When submitting Electronic Data Interchange (EDI) Claims (via a Clearinghouse) to Molina Healthcare, please utilize the payer ID.
   - EDI or electronic claims get processed faster than paper claims.
   - Providers can use any Clearinghouse of their choosing. Note that fees may apply.
3. Online submission through Web Portal Services at: www.MolinaHealthcare.com

**Claims Address**

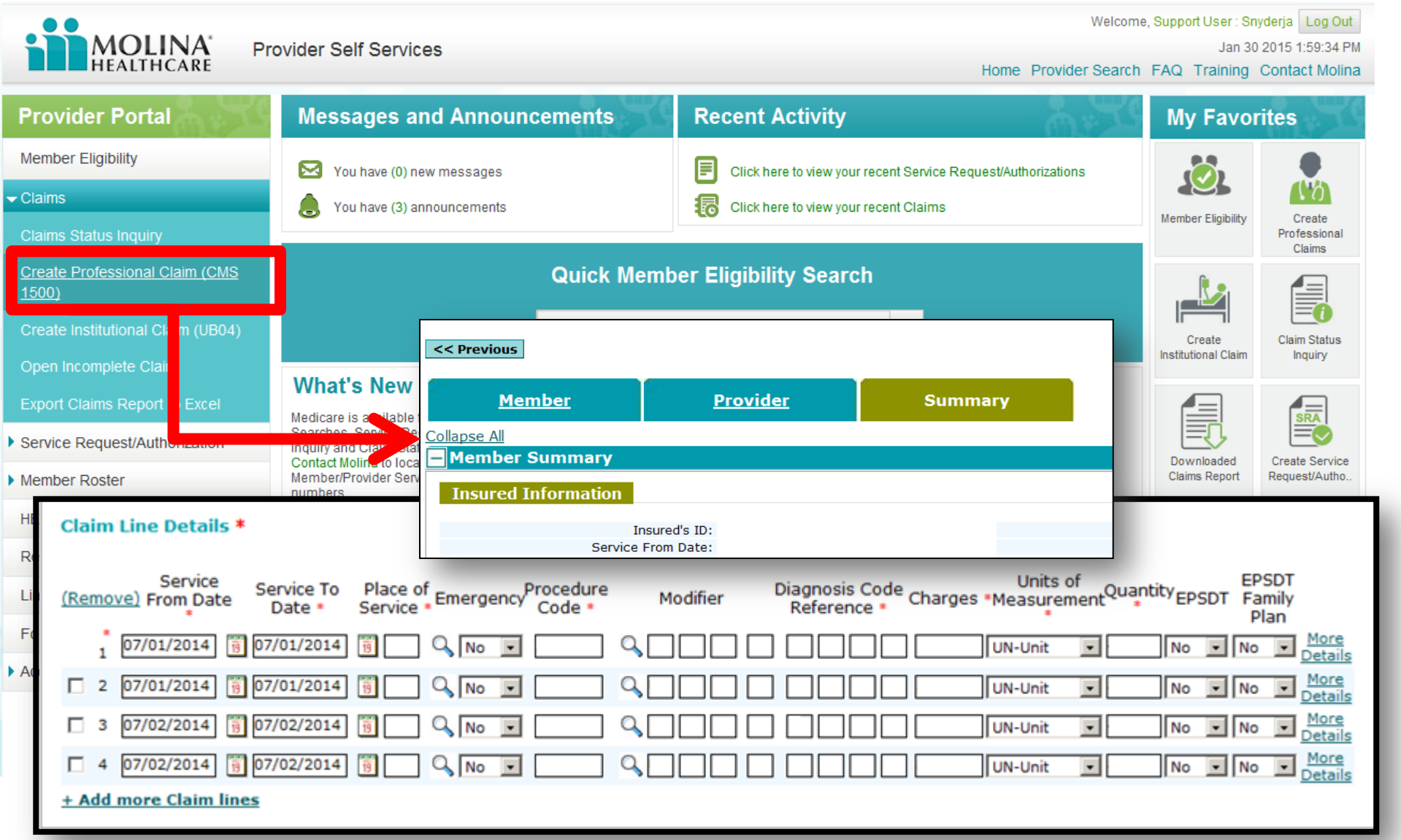
Molina Dual Options Claims
P.O. Box 22712
Long Beach, CA 90801

**EDI Claim Submission Issues**

Please call the EDI customer service line at (866) 409-2935 and/or submit an email to EDI.Claims@molinahealthcare.com

Emdeon Payer ID# 20149
Emdeon Telephone (877) 469-3263

# Claim Submission



# Claims Customer Service

- The Corrected Claims form and Claims Reconsideration/Appeal form can be found on our website www.MolinaHealthcare.com.
- Participating providers have 120 days from the date of the original remittance advice to submit corrected claims and claim reconsiderations.

The completed corrected claim and form may be mailed to:

Molina Healthcare
PO Box 22712
Long Beach, CA 90801

The competed reconsideration form and documentation can be faxed to: (800) 499-3406 or mailed to:

Molina Healthcare of Ohio
Attn: Provider Services
PO Box 349020
Columbus, OH 43234-9020

**Corrections can be sent in an electronic format.**
**In the 2300 Loop, the CLM segment (claim information), CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:**

**"7" – REPLACEMENT (Replacement of Prior Claim)**
**"8" – VOID (Void/Cancel of Prior Claim)**

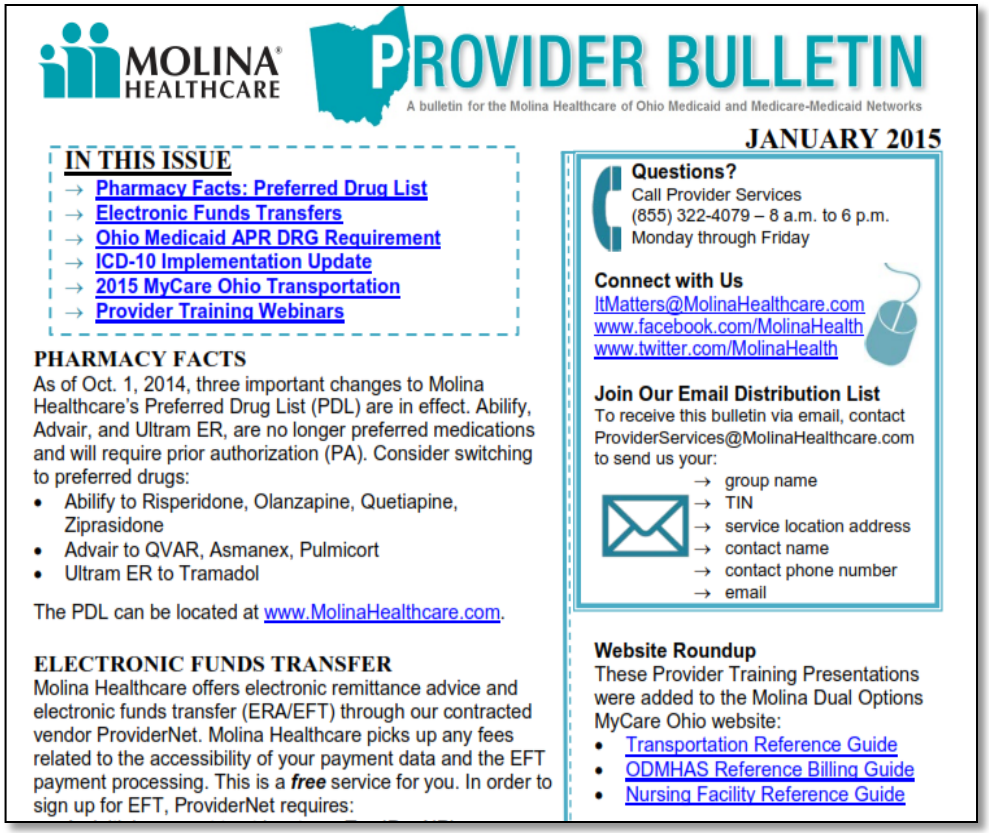
**The 2300 Loop, the REF segment (claim information), must include the original claim number issued to the claim being corrected. The original claim number can be found on the remittance advice.**
**Corrected claim bill type for UB claims are billed in Loop 2300/CLM05-01.**

# Provider Bulletin

In order to relay information regarding any system updates, a monthly Provider Bulletin is sent to Molina Healthcare's provider network.

The Provider Bulletin will include, but is not limited to:

- PA changes
- Updates to the pharmacy formulary
- Provider training opportunities
- Changes in policies that could impact claim submission, billing procedures, or appeals
- Updates to the Molina Provider Web Portal



MOLINA HEALTHCARE

PROVIDER BULLETIN

A bulletin for the Molina Healthcare of Ohio Medicaid and Medicare-Medicaid Networks

JANUARY 2015

IN THIS ISSUE

- Pharmacy Facts: Preferred Drug List
- Electronic Funds Transfers
- Ohio Medicaid APR DRG Requirement
- ICD-10 Implementation Update
- 2015 MyCare Ohio Transportation
- Provider Training Webinars

PHARMACY FACTS

As of Oct. 1, 2014, three important changes to Molina Healthcare's Preferred Drug List (PDL) are in effect. Abilify, Advair, and Ultram ER, are no longer preferred medications and will require prior authorization (PA). Consider switching to preferred drugs:

- Abilify to Risperidone, Olanzapine, Quetiapine, Ziprasidone
- Advair to QVAR, Asmanex, Pulmicort
- Ultram ER to Tramadol

The PDL can be located at www.MolinaHealthcare.com.

ELECTRONIC FUNDS TRANSFER

Molina Healthcare offers electronic remittance advice and electronic funds transfer (ERA/EFT) through our contracted vendor ProviderNet. Molina Healthcare picks up any fees related to the accessibility of your payment data and the EFT payment processing. This is a ***free*** service for you. In order to sign up for EFT, ProviderNet requires:

Questions?
Call Provider Services
(855) 322-4079 – 8 a.m. to 6 p.m.
Monday through Friday

Connect with Us
ltMatters@MolinaHealthcare.com
www.facebook.com/MolinaHealth
www.twitter.com/MolinaHealth

Join Our Email Distribution List
To receive this bulletin via email, contact ProviderServices@MolinaHealthcare.com to send us your:

- group name
- TIN
- service location address
- contact name
- contact phone number
- email

Website Roundup
These Provider Training Presentations were added to the Molina Dual Options MyCare Ohio website:

- Transportation Reference Guide
- ODMHAS Reference Billing Guide
- Nursing Facility Reference Guide

**Join Our Email Distribution List**

To receive this bulletin via email, contact ProviderServices@MolinaHealthcare.com to send us your: group name, TIN, service location address, contact name, contact phone number, email.

MOLINA HEALTHCARE

# Contact Us

| DEPARTMENT | NUMBER |
|---|---|
| Care Management | (855) 322-4079 |
| Provider Services | (855) 322-4079 Fax (866) 713-1894 |
| Claims Inquiry – Customer Service | (855) 322-4079 |
| Claims Reconsideration | (855) 322-4079 Fax (800) 499-3406 |
| Prior Authorization | (855) 322-4079 Medicare Fax (866) 290-1309 |
| Provider Web Portal Help | (866) 449-6848 |
| Member Services – Molina Dual Options (Dual Benefits) | (855) 665-4623 |
| Member Services – Molina MyCare Ohio Medicaid (Medicaid Only ) | (855) 687-7862 |
| Pharmacy | (855) 322-4079 Fax: (888) 858-3090 |
| Community Outreach | (855) 665-4623 |
| Fraud, Waste & Abuse Tip Line | (866) 606-3889<br>Fax (877) 665-4620 |
| 24-Hour Nurse Advice Line – MyCare Ohio | (855) 895-9986 TTY 711 |
| 24 Hour Nurse Advise Line – Medicaid/Medicare/Marketplace | (888) 275-8750 TTY (866) 735-2929 |
| Member Eligibility | (800) 686-1516 |

Member Services
8 a.m. to 8 p.m.
Monday - Friday

Provider Services
8 a.m. to 6 p.m.
Monday – Friday

Waiver Providers: OHMyCareLTSS@MolinaHealthcare.com

MOLINA HEALTHCARE

# Questions and Comments