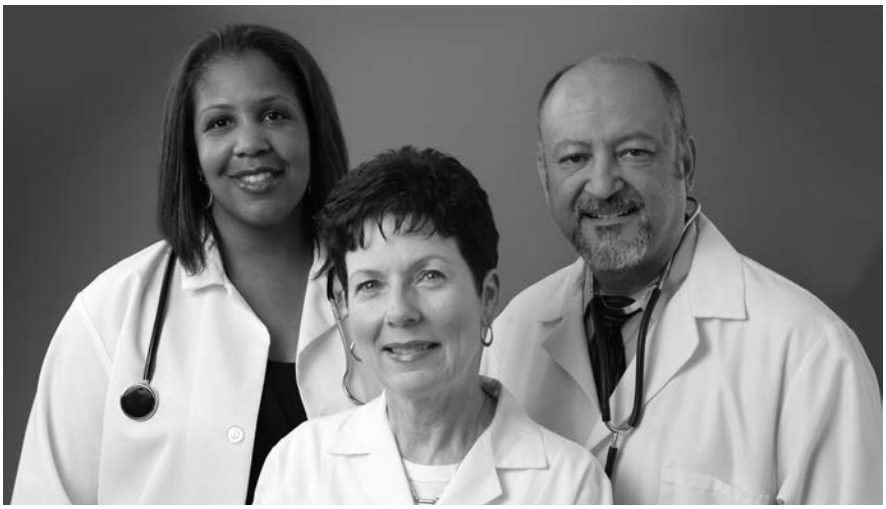
Making the Connection

Provider Newsletter • 4th Quarter 2016



In This Issue

Referring Members to In-Network Providers

Molina Healthcare maintains a network of providers to care for its members. As a reminder, provider contracts require use of participating providers, including laboratory services. Referrals are not required for members to be seen by in-network specialists; however, prior authorization may be required depending on the service provided.

At times, a provider may request a service that is unavailable or not provided within our network. Providers must get approval ahead of time from Molina Healthcare to authorize this type of specialty referral. This process is called "prior authorization."

It is very important to get a prior-authorization for members who are being referred outside of the Molina Healthcare network to prevent the member from incurring balance billed amounts.

If you have questions or concerns about a prior authorization, you may call Molina Healthcare at (855) 326-5059.

Utilize CPT II Codes for Reporting A1c Results

Molina Healthcare of Wisconsin is actively working to improve the health of our members with diabetes. In order to better monitor A1c control throughout the year, we are encouraging our providers to use CPT Category II codes that identify levels of A1c results, such as the codes listed in the table below.

CPT II Code	HbA1c Level
3044F	<7%
3045F	Between 7% and 9%
3046F	>9%

When you submit CPT Category II codes, in addition to other codes used for billing, it decreases our need for medical record abstraction and chart review. This also minimizes your administrative burden for HEDIS® and other quality-based initiatives. We are hoping this will promote an efficient method for data collection from providers while improving the quality of care for our members.
We appreciate your partnership in serving our members!

Assisting Members Living with Diabetes

We are excited to offer two programs focused on Diabetic Management; Healthy Living with Diabetes and the National Diabetes Prevention Program. The information below explains how YOU can refer your patients to either program.

What is *Healthy Living with Diabetes*?
This workshop is designed to help adults with type 2 diabetes or pre-diabetes learn self-management skills and increase confidence in managing diabetes. The workshop meets once a week for six weeks — 2-1/2 hours each session.
Healthy Living with Diabetes complements existing treatments a participant receives.

Who should you refer to this workshop?

- Adults with type 2 diabetes OR,
- Adults living with someone who has diabetes

How do I refer my Patients?
Contact Dan Klaver Health Educator with Molina Healthcare at (414) 755-6669.

What is the National Diabetes Prevention Program?
This program is designed to help adults that are at high risk for type 2 diabetes learn skills to eat healthier and be more active. This is a CDC recognized lifestyle change program focused on delaying the onset of Type II Diabetes. This program meets once per week for a 1 hour session for 16 weeks. After the initial 16 weeks the participants meet once per month for 6 months.

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Who should you send to this program?
Your patients who:

- Are 18 years or older AND
- Have a BMI ≥ 24 kg/m2 (≥22 if Asian) AND
- A diagnosis of pre-diabetes, or GDM, based on one or more
    - Fasting blood glucose (range 100 - 125 mg/dl)
    - 2-hour glucose (range 140 - 199 mg/dl)
    - HbA1c (range 5.7 - 6.4)
    - Previous GDM (may be self-reported)

How do I refer my Patients?
Contact Dan Klaver, Health Educator at (414) 755-6669.

Marketing Policies for Providers

The Wisconsin Department of Health Services (DHS) recently released an "Outreach and Communication Guide" which outlines allowable communication and outreach practices when health maintenance organizations (HMOs) and HMO-contracted providers communicate with HMO members and potential members. While much of the guide focuses on policies regarding how HMOs communicate with their members and potential members, there are some policies that affect Molina's contracted providers.

Below are reminders of what Molina's contracted providers can and cannot do when it comes to communicating with Medicaid enrollees regarding HMOs:

- Providers are allowed to educate/inform their patients about the BadgerCare Plus and Medicaid SSI HMOs with which they contract.
- Providers are allowed to inform their patients of the benefits, services, and specialty care services offered through the HMOs in which they participate.
- Providers are allowed to give a patient contact information for a particular HMO, but only at the patient's request.
- Providers are allowed to assist potentially eligible individuals with enrollment in the BadgerCare Plus and/or Medicaid SSI programs by helping them:
    - Apply online at the Access website: www.access.wisconsin.gov;
    - Complete the online form at: www.dhs.wisconsin.gov/forms/F1/F10182.pdf
    - Call or go to their county IM agency or tribal agency to complete an application; for a map of the different IM agencies per county, go to: www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm
- Providers are allowed to assist potentially eligible individuals with the BadgerCare Plus express enrollment process, as described on the ForwardHealth Portal at www.forwardhealth.wi.gov, if they qualify.
- Providers are allowed to refer patients with questions about the BadgerCare Plus and/or Medicaid SSI programs to an HMO Enrollment Specialist at (800) 291-2002.
- HMOs are allowed to conduct orientations, health fairs, or community baby showers for their members in a private setting at a provider's office.

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- Providers are prohibited from recommending one HMO over another HMO, offering patients incentives to select one HMO over another HMO, or assisting the patient in deciding to select a specific HMO.

If there are any questions about these policies, please contact WIProviderEngagement@MolinaHealthcare.com.

Convenience Care Clinics

Services rendered in a walk-in retail convenient care clinic are suitable for treatment of minor acute conditions, limited preventive services and vaccines, please be mindful that Medicaid allows reimbursement only for members aged 6 years and older when rendered by a Medicaid-enrolled nurse practitioner, physician assistant, or physician in a walk-in retail or convenient care clinic.

Please refer to Forward Health topic #17457 to learn more.
https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Print.aspx?ia=1&p=1&sa=50&s=2&c=61&nt=Services+Rendered+in+Walk-In+Retail+or+Convenient+Care+Clinics

Reminder- Updating W-9's

Molina Healthcare requires all providers to have a current W-9 Form on file certifying your Taxpayer Identification Number (TIN). This document is issued by the United States Internal Revenue Service (IRS). Molina Healthcare uses it to update information such as; TIN Owner Name, DBA Name and Tax ID's when received with a Provider Information Update Form. The business name, address and tax identification number must match your claims and should contain the business name as it appears on your W-9. If the W-9 does not match your claims we may be unable to process your claims.

For your convenience, you can download a W-9 Form and Provider Information Update Form from:
http://www.molinahealthcare.com/providers/wi/medicaid/forms/Pages/fuf.aspx

Updated W-9 and Provider Information Update Forms can be faxed to (414) 214-2481, Attention: Provider Services or email to WIProviderEngagement@MolinaHealthcare.com.

Transitions of Care Program

Molina Healthcare of Wisconsin offers an important member-centric program called Transitions of Care (TOC). This program is staffed by TOC coaches - Registered Nurses and Social Workers with experience in case management, behavioral health, and healthcare. The four to six week intervention is designed to provide an added layer of support for Molina members who are at risk and experience hospitalizations, whether planned or unplanned. Molina members currently in an inpatient setting are eligible for TOC with the emphasis on targeted conditions of diabetes, asthma, COPD, CHF, cellulitis, pneumonia and behavioral health conditions.

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The program begins with the TOC coach contacting the member in the hospital, whether telephonically or in person, to establish rapport and offer support. Throughout the program, discharge instructions are reinforced, medications are reviewed, and upcoming appointments are confirmed or coordinated. In addition, important topics such as medication adherence, follow-up appointments, food insecurity, housing and transportation will be revaluated. Additional interventions may focus around attending provider visits to assist Molina members with creating and understanding the agreed upon plan for care. If the member would continue to benefit from support upon the end of the intervention, a referral to ongoing case management or other services will be provided.

For more information on the TOC program, or to make a referral, please contact Megan Keil at (414) 831-3378.

Fighting the Flu!

Flu season is here! Molina would like to thank you for educating your patients on the importance of the flu vaccination. We are here to partner with our providers on encouraging members to receive their flu shots.

As you know, the flu vaccine is the best defense against the flu, possible complications, and the potential to spread to others.

Please check the Center for Disease Control and Prevention (CDC) website for more details on what's new for the 2016-2017 flu season, this can be found when you visit the following website: http://www.cdc.gov/flu/about/season/flu-season-2016-2017.htm.

Thank you for the care you give our members and your partnership in keeping our community healthy!

2016 Model of Care

The Centers for Medicare and Medicaid (CMS) requires that all Molina contracted providers complete the annual Model of Care (MOC) training, no later than December 1, 2016.

This basic training reviews the Molina Healthcare duals program and describes how Molina Healthcare and its contracted providers work together to successfully deliver the duals MOC program.

To view the 2016 Model of Care Provider Training please visit: http://www.molinahealthcare.com/providers/common/medicare/Pages/medicare.aspx.

Once you have completed the training please complete the 2016 Model of Care Provider Training Attestation form. The completed form can be faxed to your Provider Representative at (414) 214-2481 or emailed to WIProviderEngagement@MolinaHealthcare.com.

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Provider Orientation Webinars

Molina Healthcare of Wisconsin's Provider Education Webinars are open to all Network Providers, their medical and office staff. Webinars are hosted through WebEx, which allows you to listen to the presentation by phone or by viewing it on your computer all webinars include a live person and subject matter expert to answer your questions.

DATE	TIME	WEBINAR TOPIC	LINK TO JOIN YOUR WEB_EX	Meeting number
October				
10/6/2016	9:30 AM	Provider Orientation	https://molina.webex.com/molina/j.php?MTID=m2689e4e1575566d62cdf9520cc630af3	801 450 161
10/18/2016	10:30 AM	Provider Orientation	https://molina.webex.com/molina/j.php?MTID=me073b5841abcb5ab280466267a188ef0	808 155 102
10/20/2016	10:00 AM	Provider Orientation	https://molina.webex.com/molina/j.php?MTID=m801f02b712fc58f1a3888b69a263bf23	800 897 851
10/25/2016	10:00 AM	Provider Orientation	https://molina.webex.com/molina/j.php?MTID=m646419313fd99acc2f0c36fe3f114926	800 698 281
November				
11/8/2016	10:00 AM	Provider Orientation	https://molina.webex.com/molina/j.php?MTID=md18ae0bffc565cc0f7cc24186b177f62	803 580 228
11/3/2016	10:00 AM	Provider Orientation	https://molina.webex.com/molina/j.php?MTID=ma6d04b392bd6e9423c52719be3dca5a5	807 301 927
11/24/2016	10:00 AM	Provider Orientation	https://molina.webex.com/molina/j.php?MTID=m86065f32c0532151de7b557a01f9f07d	804 079 455
11/17/2016	10:00 AM	Provider Orientation	https://molina.webex.com/molina/j.php?MTID=m0ee6516b2167dd736d7a818d80a0ba83	801 902 498
December				
12/1/2016	10:00 AM	Provider Orientation	https://molina.webex.com/molina/j.php?MTID=m3a0a7e799480f19b44eb21f5279d8f21	802 489 122
12/8/2016	10:00 AM	Provider Orientation	https://molina.webex.com/molina/j.php?MTID=mc660071096224b7eb43e0dc67b22fd78	808 548 403
12/13/2016	10:00 AM	Provider Orientation	https://molina.webex.com/molina/j.php?MTID=m61308c1c205aef65c37ee15f63b9d6b6	806 173 101
12/20/2016	10:00 AM	Provider Orientation	https://molina.webex.com/molina/j.php?MTID=mf2d60311981d23c1c4b0c06a93d367fe	807 577 687

Please encourage appropriate staff to register for these informative, educational opportunities.
Please e-mail WIProviderEngagement@Molinahealthcare.com to be added to our e-mail list and be the first to learn about new webinars.

Updating Provider Information

Updating provider information is important to Molina and also when serving our members. Updating information is easy. A provider can notify us by writing, fax or e-mail with any of the following changes:

- When changing in practice ownership, name, address, phone number or Federal Tax ID numbers
- When adding a new physician to the practice or if a physician is leaving the practice
- When loss or suspension of your license to practice
- When in the event of bankruptcy or insolvency
- When any suspension, exclusion, debarment, or other sanction from a State or federally funded healthcare program
- When any indictment, arrest, conviction for a felony, or any criminal charge related to your practice
- When any material changes in cancellation or termination of liability insurance
- When a provider is closing their practice to new patients and vice versa
- When (least 90 days before) terminating affiliation with Molina Healthcare of Wisconsin or one of its provider networks (refer to your contract for specific termination terms)

Please submit changes via mail, fax, or e-mail:
Molina Health Care of Wisconsin
11200 West Parkland Avenue
Milwaukee, WI 53224-3127
FAX: (414) 214-2490
E-MAIL: WIProviderEngagement@MolinaHealthcare.com

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Molina Healthcare Prior Authorization Requirements

Molina requires prior authorization for certain services, procedures, surgeries, devices, supplies, drugs and other treatment. Molina does not require an authorization for a referral to a specialist, if the specialist is an in-network provider for the specific line of business. Referrals to specialty care providers outside of the network require prior authorization.

Molina maintains a specific list of prior authorization requirements that is available to all Molina contracted providers via the provider manual and the Molina website. Coverage is not authorized until the request has been reviewed and approved by the Molina Healthcare services Department. Certain services do not require prior authorization. Some services are not a covered benefit.

Please refer to the following links for each line of business to determine if the service is a covered benefit.

- **Medicare** - CMS website - https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx
- **Medicaid** - Forward Health website - https://www.forwardhealth.wi.gov/WIPortal/Default.aspx
- **Marketplace** - Molina Healthcare website – Specific EOC http://www.molinahealthcare.com/providers/wi/medicaid/Pages/home.aspx

Providers may submit requests for prior authorization via fax to (877) 708-2117. Requests for services will be handled by Molina's Healthcare Services department when:

- The request for services is a new request.
- The request for a service that had a previous adverse determination and the date of the request is more than 60 days from the submission of the original request.

All requests for authorization will be handled as expeditiously as the member's health condition requires, no later than 14 days following the date of receipt of the request of service. Urgent requests will be handled with 72 hours of receipt.

If an authorization request is denied, the provider will have 5 business days to submit additional information for reconsideration or request to schedule a peer to peer review by calling (414) 214-2495, ext. 302665.

Authorization requests for services that are not a covered benefit will be administratively denied. These types of denials will not be eligible for a peer to peer/reconsideration as they are a non-covered benefit. Please refer to the websites above for each line of business to determine if the service is a covered benefit.

Emergency Department
Visits to the emergency room do not require an authorization, however, if the member is admitted to inpatient status the facility must notify Molina within 24 hours of the admission or by the next business day.

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Inpatient Authorization
Notification of an inpatient admission is required within 24 hours of the admission or the next business day. Molina Healthcare requires that members must meet inpatient medical necessity criteria during their stay in order to qualify for inpatient status. All inpatient requests will be reviewed for the most appropriate level of care included but not limited to observation level of care. Level of care will be reviewed throughout the inpatient stay. The facility needs to notify Molina of a change of level of care (i.e. observation to inpatient, ICU to medical or telemetry to medical etc.). Molina will use a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is updated regularly, and is reviewed and approved annually. CMS and state regulations, Molina clinical policies, and benefit guidance will be used as well *as nationally accepted evidence based criteria guidelines such as InterQual or MCG criteria.*

Fluoride and Oral Screenings

The Role of Primary Care Physicians is very important the first year of a child's life. Reaching out to children during the first year can make a positive impact on the child's health. When a Primary Care Physician educates families on good Oral health practices, the primary care providers should also include an oral check up during the child's exam. Using Fluoride Varnish is the shield a primary care physician can apply to patients to protect their teeth. Oral Screening is an effective tool in early detection of dental disease.

Marketplace Ace Forms

Efforts are underway to have our Marketplace members have an annual examination by their Primary Care Provider to document their chronic conditions by December 31, 2016. For more information please contact our Risk Adjustment Department at WIRiskAdjustment@MolinaHealthcare.com.

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Balance Billing Members

Balance Billing is one of the most common phone calls we receive from our members. We want to ensure our members are not being balance billed. Below are both Medicaid and Marketplace guidelines regarding member billing.

Medicaid
In accordance with State and Federal laws, if a provider inappropriately collects payment from an enrolled Member or Authorized Representative acting on behalf of the Member, that provider may be subject to program sanctions including termination of Medicaid enrollment. In addition, the provider may also be fined, imprisoned, or both pursuant to Section 42 USC s. 1320a-7b and Wis. Stats. 49.49 (3m).

If you have inquiries regarding member eligibility and/or if a specific service is covered please call us at (855) 326-5059.

Marketplace
All Marketplace plans must cover the following list of preventive services without charging you a copayment or coinsurance. This is true even for members who have not met their annual deductibles. This list applies only when these services are delivered by a network provider.

- **Abdominal Aortic Aneurysm one-time screening** for men of specified ages who have ever smoked
- **Alcohol Misuse screening and counseling**
- **Aspirin use** to prevent cardiovascular disease for men and women of certain ages
- **Blood Pressure screening** for all adults
- **Cholesterol screening** for adults of certain ages or at higher risk
- **Colorectal Cancer screening** for adults over 50
- **Depression screening** for adults
- **Diabetes (Type 2) screening** for adults with high blood pressure
- **Diet counseling** for adults at higher risk for chronic disease
- **HIV screening** for everyone ages 15 to 65, and other ages at increased risk
- **Immunization vaccines** for adults--doses, recommended ages, and recommended populations vary:
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster
  - Human Papillomavirus
  - Influenza (Flu Shot)
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Tetanus, Diphtheria, Pertussis
  - Varicella
- **Obesity screening and counseling** for all adults
- **Sexually Transmitted Infection (STI) prevention counseling** for adults at higher risk
- **Syphilis screening** for all adults at higher risk
- **Tobacco Use screening** for all adults and cessation interventions for tobacco users

If you have inquiries regarding member eligibility and/or if a specific service is covered please call us at (855) 326-5059.

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Introducing the Hypertension Toolkit

Molina Healthcare is excited to share our Hypertension Toolkit with you. We developed this toolkit because we understand the importance of efficiently managing hypertension in our member population.

The toolkit contains resources for practitioners and medical staff, including:

- The Hypertension Guideline Management Algorithm
- A formulary for hypertension medication
- Educational materials that can be shared with patients
- Tips and reminders for taking accurate blood pressure readings

We hope you will find this toolkit useful. We appreciate the care you provide to our members. We are happy to help and collaborate to deliver optimal care to patients with cardiovascular disease!
Stay tuned, we will be delivering one to your office(s) soon.

Network Updates

Molina Healthcare would like to remind our Medicaid providers and billers about the following topics to help facilitate timely payments or to avoid costly recoupments.

DME Modifiers – Some codes require a modifier for reimbursement. Include the RT (right side) or LT (left side) modifier, as appropriate, on a separate detail line on the claim. Claims submitted with RT and LT on the same detail line will be rejected. Also remember, all DME must be billed on the CMS-1500 for reimbursement. Please reference the link below for more information.

- **Forward Health topic #2047-**
  https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=17&s=2&c=10&nt=Procedure+Codes

Personal Care Services – For personal care and travel time, one unit of service is equal to 15 minutes. When calculating the number of units that should be billed, total the number of personal care hours or travel time hours for that DOS. Each DOS should have 1 line entered for PCW and 1 line for travel time, if applicable.

	INCORRECT BILLING				
0579	PCW TRAVEL TIME	T1019 U3	121415	1	4.02
0579	PCW TRAVEL TIME	T1019 U3	121415	1	4.02
0579	PCW TRAVEL TIME	T1019 U3	121415	1	4.02
	CORRECT BILLING				
0579	PCW TRAVEL TIME	T1019 U3	121415	3	12.06

PCW travel time for DOS 12/14/2015 to be correctly billed should appear on 1 line with 3 units.

	INCORRECT BILLING				
0570	PERSONAL CARE	T1019	112415	9	36.18
0570	PERSONAL CARE	T1019	112415	4	16.08
	CORRECT BILLING				
0570	PERSONAL CARE	T1019	112415	13	52.26

PCW services should combine units for each DOS; DOS 11/24/2015 should bill T1019 with 13 units.
Please reference the link below for more information.

- **Forward Health topic #2479-**
https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=47&s=2&c=10&nt=Units+of+Service

Outpatient Submissions - EAPG has given us a new set of rules for Outpatient facility claim submission. Beginning 1/1/2015 providers must submit all services for the same date of service on the same claim. If there are services that are unrelated to the original visit the provider must indicate a condition code G0 (zero) - Distinct medical visit on the second claim submitted.

Example: The member had an MRI performed for headaches that was ordered from Dr. Smith. Then the member returns later that same day to the ER due to a fall. These services are unrelated and the second claim should be submitted with a G0 modifier. Please reference the link below for more information.

- **Forward Health topic #1371**-
https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=43&s=4&c=13&nt=Dates+of+Service+and+Multiple+Visits

Per Forward Health Update 2010-114: Licensed and certified psychotherapists will continue to be reimbursed at the Master's degree level (modifier "HO") for outpatient mental health and outpatient substance abuse services. The only allowable place of service (POS) code is POS 11 (office). We have been seeing Licensed psychotherapists submitting claims for place of service 12 (Home); services rendered in any POS other than 11 (office) will be denied. Travel is not able to be submitted independently.

The update can be found here: https://www.forwardhealth.wi.gov/kw/pdf/2010-114.pdf

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Milwaukee, WI 53224

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