Making the Connection

Provider Newsletter • 1st Quarter 2018

Molina Healthcare plans to welcome new members through WI SSI Expansion

Starting in January 2018, in order to provide high quality care for adult Wisconsin Medicaid members, certain Supplemental Security Income (SSI) members must enroll in an HMO of the member's choice. Members who do not choose an HMO will have one chosen for them. HMO enrollment will be done by region with the last region enrolling by June 2018.

Molina Healthcare welcomes these new members and would like to make their transition as simple as possible for you, to do this Molina will:

- Honor existing authorizations for PCW services until the authorization expires or for 90 days, whichever is greater.
- Assign a case manager to each member to assist them with scheduling appointments and transportation needs.
- **Existing Prior Authorizations will be available on the Provider Portal**
    - If you would like assistance with viewing authorizations for new members on the portal, please e-mail WIProviderEngagement@Molinahealthcare.com.

Members affected by this change will get a letter in the mail. If you have questions about this process, call the HMO enrollment specialist at (800) 291-2002.

Members currently enrolled in an SSI HMO, children under age 18 with Medicaid SSI, tribal members, and members dually enrolled in Medicare are not affected.

Contents

Molina Healthcare provides SSI in the counties listed below.

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Forest	Brown	Green Lakes	Dodge	Kenosha	Milwaukee
Langlade	Calumet	Marquette	Jefferson	Ozaukee	
Lincoln	Door	Portage	Walworth	Racine	
Marathon	Florence	Waushara	Wood	Washington	
Oneida	Fond Du Lac			Waukesha	
Shawano	Kewaunee				
Taylor	Manitowoc				
Vilas	Marinette				
	Oconto				
	Outagamie				
	Sheboygan				
	Waupaca				
	Winnebago				

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New Provider Appeal Process

Molina Healthcare of WI will no longer accept or process Appeals received via Mail.

Provider appeals will only be accepted in the following manner:

- **Provider Portal:** The Provider Portal can be found at Provider.molinahealthcare.com
- **Email:** MWIAppeals@MolinaHealthcare.com
  - The Provider Appeal Form must be completed correctly in full.
  - The form can be found on MolinaHealthcare.com under provider Frequently Used Forms
- **Fax:** (844) 251-1446
  - The Provider Appeal Form must be completed correctly in full.
  - The form can be found on MolinaHealthcare.com under provider Frequently Used Forms

Please e-mail questions to WIProviderEngagement@MolinaHealthcare.com.

Corrected Claim Billing Requirements

Molina Healthcare considers corrected claims as new claims for processing purposes. Corrected claims must be submitted electronically with the appropriate fields on the 837I or 837P completed. Molina's Provider Portal includes functionality to submit corrected Institutional and Professional claims. Corrected claims must include the correct coding to denote if the claim is Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P.

Providers can submit corrected claims when changing or adding information, such as a change in coding. There are two ways to submit a corrected claim to Molina Healthcare:

1. Electronic Data Interchange (EDI)
2. Molina Healthcare's Provider Web Portal

When submitting corrected claims to Molina Healthcare, follow these billing requirements:

- Always submit through the Web Portal or electronically as indicated in the steps below.
- The original claim number must be included or the claim will be denied.
- Do not submit corrected claims through the claims reconsideration process.
- Always include the original claim in its entirety with the corrections made.
- Do not submit a corrected claim with only codes that were edited by Molina Healthcare on the original claim.

1. Web Portal Submission
   - Log in with your username and password.
   - Select "Create a professional claim" from the left menu.
   - Select the radio button for the correct claim option.
   - Enter the ID number of the claim you want to correct.

- Make corrections and add supporting documents explanation of benefits (EOB).
- Submit your claim.

2. Electronic Submission

CMS 1500

- 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)
- In the 2300 Loop, the REF segment (claim information), **must** include the original claim number of the claim being corrected, found on the remittance advice.

UB04

- Bill type for UB claims are billed in loop 2300/CLM05-1. In Bill Type for UB, the 7 or 8 goes in the third digit for "frequency."
- The 2300 Loop, the REF segment (claim information), **must** include the original claim number of the claim being corrected, found on the remittance advice.

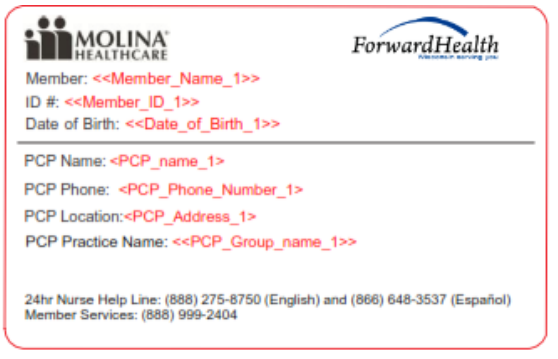
Claims submitted without the correct coding will be denied.

To learn more, see our Claim Features Training Guide at MolinaHealthcare.com under the "Manual" tab. You can also e-mail WIProviderEngagement@Molinahealthcare.com with additional questions.

2018 Provider Manual now online!

Molina Healthcare of Wisconsin recently updated the Provider manual. Visit molinahealthcare.com> I'm a Health care Professional> manual to view the latest version. If you have questions about this communication, please contact Provider Services at WIProviderEngagement@MolinaHealthcare.com.

Molina Healthcare members will have member ID cards effective 1-1-2018


MOLINA HEALTHCARE
ForwardHealth
Member: <<Member_Name_1>>
ID #: <<Member_ID_1>>
Date of Birth: <<Date_of_Birth_1>>
PCP Name: <PCP_name_1>
PCP Phone: <PCP_Phone_Number_1>
PCP Location:<PCP_Address_1>
PCP Practice Name: <<PCP_Group_name_1>>
24hr Nurse Help Line: (888) 275-8750 (English) and (866) 648-3537 (Español)
Member Services: (888) 999-2404

Molina Healthcare members will begin showing the ID cards below effective 1-1-2018.

Patients may visit your office without their member ID number or a copy of their card. You can search for patients on the Provider Portal, our secure provider website, with the Eligibility and Benefits Inquiry transaction. All you need is their name and date of birth.

MolinaHealthcare.com

Provider Information Updates

Molina Healthcare requires Providers to notify us of all provider changes.

Please utilize and follow the instructions on the Molina Provider Information Change Form found at MolinaHealthcare.com under frequently used forms. Directions for completion and submission are provided on the form.

If you have questions, please contact your Provider Service Representative at WIProviderEngagement@MolinaHealthcare.com

Please submit changes via fax or e-mail:
FAX: (877) 556-5863
E-MAIL: WIProviderEngagement@MolinaHealthcare.com

Changes to NICU claims processing

Effective for NICU claims processed on and after 12/11/2017, all NICU claims where an authorization exists and experimental/investigational drugs and treatments have been DENIED will require an itemized bill, when the claim requires one of the following payment methodologies to be applied: Stop-loss, Outlier, or Percentage of Billed Charges.

Molina Claim Adjustment Reason Codes (CARC) & Remittance Advice Remark Codes (RARC) Redesign

Molina has standardized the HIPAA complaint CARC and RARC remit messages that will be attached to providers' and members' Electronic Remittance Advice (ERA or 835), Explanation of Payment (EOP) and/or Explanation of Benefits (EOB). This project has developed an enterprise framework to identify and maintain all remit business rules to remain compliant with CMS and HIPAA. Providers and members can expect to see these changes on their 835, ERA, EOP and/or EOB after December 15, 2017.

Please contact Molina's Provider Services for questions at WIProviderEngagement@MolinaHealthcare.com.

New Legislation for Dental Hygienists

Wisconsin's Governor Walker signs legislation allowing Dental Hygienists to practice in more settings with fewer restrictions.

What's in it for you?

The new law, allows dental hygienists to work for hospitals, medical clinics, group homes, correctional facilities, shelters, nursing homes, day care centers for children and adults without the direct supervision or authorization of a dentist. Prior to this legislation, only a dentist could authorize a hygienist to perform services for patients in those settings.

To read more about this new opportunity to add resources to your practice please visit Wisconsin Dental Hygienist Association at the link below.

http://widha.org/grandteton/wp-content/uploads/PressRelease-c-SettingsLegislation-2017-c.pdf

Billing Reminders

Molina Healthcare would like to remind our providers and billers about the following ForwardHealth topics to help facilitate timely payments or to avoid costly recoupments. Molina Healthcare will recoup on claims submitted outside of the guidelines listed below.

- **Behavioral Health Professional Level Modifiers –** Per ForwardHealth topics 6218 and 6123, Psychotherapist, Psychologist, Psychiatrist and APNP with Psychiatric Specialty are required to submit a professional level modifier based on their degree. As an example, if a provider holds a Master's Degree/psychotherapist (modifier HO) and a PhD/psychologist (modifier HP), the provider should only submit a modifier of HP.

  Example, code 90834 for a PhD provider, should be submitted as 90834-HP **not** 90834-HO-HP. The higher level the degree the provider holds the higher the reimbursement.
  - https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=44&s=2&c=10

- **DME Rental Items –** ForwardHealth Topic # 1729

  Rental items billed (indicated with RR modifier) must have "from" and "to" DOS to cover date span of rental. If the item was provided on consecutive days, those dates may be indicated as a range of dates by entering the first date as the "from" DOS and the last date as the "to" DOS. The number of days indicated must equal the number of days within the range. Rental items must be ranged within the same calendar month per detail line. This means if rental claim is from 1/15/2017 to 2/15/2017 the item must be entered onto 2 separate claim lines to indicate DOS for 1/15/2017 to 1/31/2017 and 2/1/2017 to 2/15/2017 with the appropriate units per day.

WRONG WAY DATE SPAN;

MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS	MODIFIER			POINTER	$ CHARGES	UNITS	Plan	QUAL.	PROVIDER ID. #
06	29	16	07	20	16	12		K0606	KF	RR	KH	A B	$3,550 00	22.00	N	NPI	1164535274
																NPI	

CORRECT WAY DATE SPAN;

	MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS	MODIFIER			POINTER	$ CHARGES	OR UNITS	Family Plan	QUAL.	PROVIDER ID. #
1	06	29	16	06	30	16	12		K0606	KF	RR	KH	A B	320 00	2	N	NPI	1164535274
2	07	01	16	07	20	16	12		K0606	KF	RR	KH	A B	3226 00	20	N	NPI	1164535274

- **Facility Outpatient Submissions –** EAPG has given us a new set of rules for Medicaid Outpatient facility claim submission. Beginning 1/1/2015 providers billing OP facility services must submit all charges for the same date of service on one 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. As an example the member has an MRI performed for headaches and ordered from Dr. Smith and then return later in the 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 see the attached link from ForwardHealth: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspxia=1&p=1&sa=43&s=4&c=13&nt=Dates+of+Service+and+Multiple+Visits.

- **Day Treatment Claims –** For Medicaid claim reimbursement, day treatment must be submitted on a CMS-1500 per the requirements set by ForwardHealth. Remember to include the appropriate required modifier.

- **Office Visit Procedure G0463 –** Providers, please note that Medicare procedure G0463 is an office visit procedure that's used for Medicare claim when services are part of Hospital Clinic based billing. However, this procedure should not be utilized for Medicaid claim submissions if the member does not have a Medicare primary plan. Medicaid claims are required to submit the standard office visit procedure codes from the CPT book based on the documentation of the visit.

- **Laboratory Services –** As a reminder, provider contracts require use of participating providers. This includes laboratory services. Providers are required to submit specimens to participating laboratories. A complete list of participating laboratories can be found at: http://www.molinahealthcare.com/providers/wi/medicaid/Pages/home.aspx

- **Outpatient Therapy Services –** ForwardHealth update: https://www.forwardhealth.wi.gov/kw/pdf/2011-76.pdf (2011-76) states that providers submitting services for Medicaid outpatient hospital physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) services are reminded to submit claims using a professional claim (CMS-1500) to receive reimbursement. The exceptions to this requirement are:
  - Claims for PT, OT, and SLP evaluations and reevaluations provided on the same DOS as an outpatient hospital specialty clinic visit.
  - Claims for PT and OT services provided during an outpatient hospital (as defined above) cardiac rehabilitation visit, with cardiac rehabilitation team monitoring or physician electrocardiographic monitoring also provided.
  - Provider-submitted Medicare crossover claims for outpatient hospital PT, OT, and SLP services previously submitted to Medicare on an institutional claim.

- **Skilled Nursing Facilities –**
  - ForwardHealth Topics # 3484
    https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Print.aspx?ia=1&p=1&sa=40&s=4&c=13&nt=UB-04+(CMS+1450)+Claim+Form+Instructions+for+Nursing+Home+Services
  - ForwardHealth Topic #3448
    https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Print.aspx?ia=1&p=1&sa=32&s=4&c=13&nt=UB-04+(CMS+1450)+Claim+Form+Instructions+for+Inpatient+Hospital+Services

  According to ForwardHealth instructions, the date of discharge or death is not included in the covered days or units for SNFs and all inpatient facilities. The entire length of stay is required to be shown in the "Statement Covers Period" and Medicaid does not reimburse the date of discharge, transfer or death.
  - Additionally, value code "80" is to indicate covered days, "81" for non-covered days; these are required for all inpatient submissions, including SNF stays.

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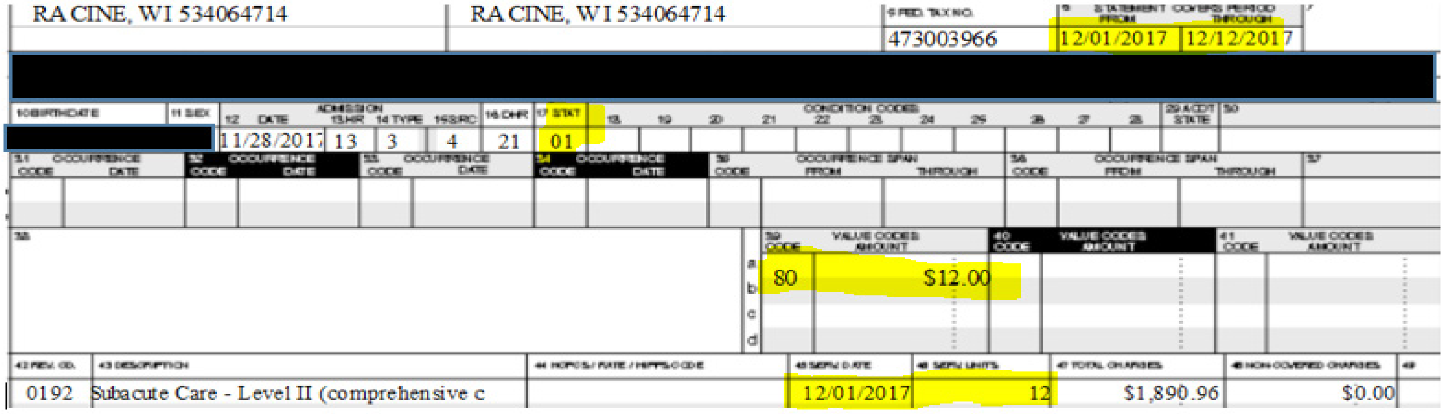
THIS EXAMPLE IS SUBMITTED **INCORRECTLY**, reasons are shown below;


RACINE, WI 534064714 | RACINE, WI 534064714 | 5 FED. TAX NO. 473003966 | 6 STATEMENT COVERS PERIOD FROM 12/01/2017 THROUGH 12/12/2017

[redacted]

10 BIRTHDATE [redacted] | 11 SEX | ADMISSION 12 DATE 11/28/2017 | 13 HR 13 | 14 TYPE 3 | 15 SRC 4 | 16 DHR 21 | 17 STAT 01 | CONDITION CODES 18–28 | 29 ACDT STATE | 30

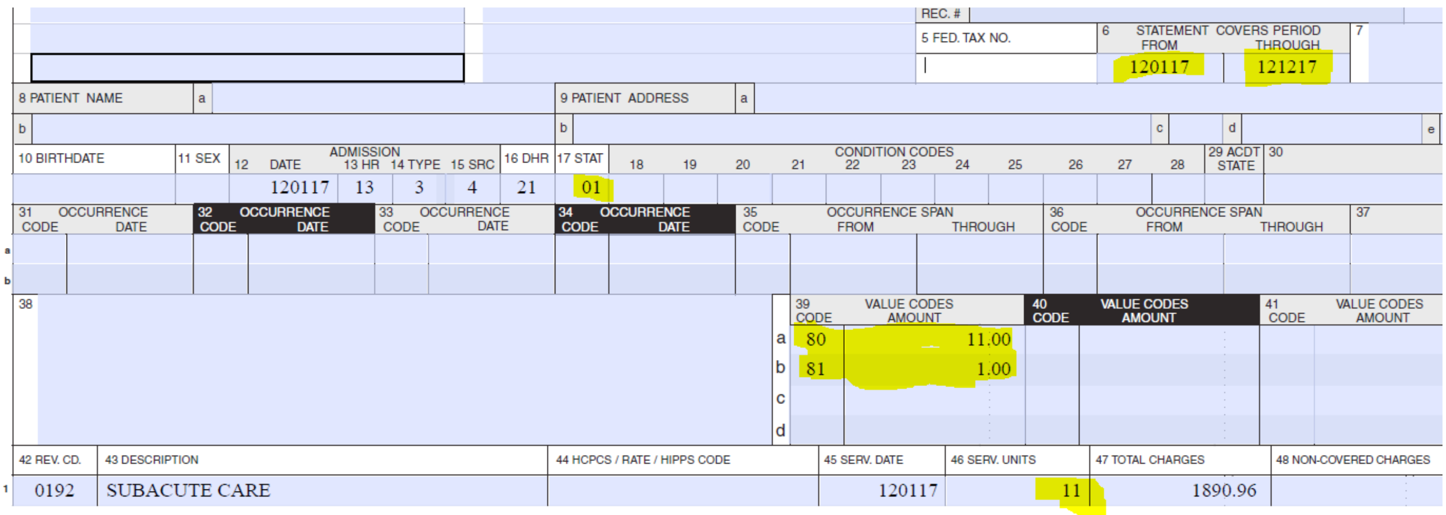
31–34 OCCURRENCE CODE / DATE | 35–36 OCCURRENCE SPAN CODE / FROM / THROUGH | 37

38 | 39 VALUE CODES CODE / AMOUNT: a 80 $12.00 | 40 VALUE CODES CODE / AMOUNT | 41 VALUE CODES CODE / AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0192	Subacute Care - Level II (comprehensive c		12/01/2017	12	$1,890.96	$0.00	

- Discharge status is 01 to indicate member discharged to home.
- Statement covered period from 12/1/17 – 12/12/2017 should equal 11 days (discharge date is not billable) instead of 12 days submitted.
- Value code "80" should be 11.00 (to indicate 11 days) and "81" with 1.00 (to indicate discharge date). **DO NOT COUNT THE DAY OF DISCHARGE FOR COVERED DAYS.**

CORRECTLY SUBMITTED EXAMPLE;


REC. # | 5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM 120117 THROUGH 121217 | 7

8 PATIENT NAME a b | 9 PATIENT ADDRESS a b c d e

10 BIRTHDATE | 11 SEX | ADMISSION 12 DATE 120117 | 13 HR 13 | 14 TYPE 3 | 15 SRC 4 | 16 DHR 21 | 17 STAT 01 | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29 ACDT STATE | 30

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38 | 39 VALUE CODES CODE AMOUNT: a 80 11.00; b 81 1.00; c; d | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
1 0192	SUBACUTE CARE		120117	11	1890.96	

- Discharge status 01; discharge date 12/12/17 is not reimbursable.
- Value code "80" indicates 11 covered days and "81" to indicate non-covered discharge date. The sum of covered and non-covered days equal the number of "From-Through" period in box 6.

Form Locator 46 – Service Units
Enter the number of covered accommodation days or ancillary units of service for each line item. Do not count or include the day of discharge/death for accommodation codes. Do not include Medicare coinsurance days. The sum of the accommodation days must equal the billing period in Form Locator 43 and must equal the total days indicated in the amount field with value code "80" in Form Locators 39-41 a-d. For transportation services, enter the number of miles.

Form Locators 39-41 a-d – Value Code and Amount
Enter the applicable value code and associated amount. Enter covered days using value code "80" and enter the number of covered days in the corresponding amount field using two decimal places. (For example, to indicate one day, providers would enter "1.00;" to indicate 12 days, providers would enter "12.00.") Enter noncovered days using value code '81" and enter the number of noncovered days in the amount field using two decimal places. Do not count the day of discharge for covered days. For noncovered days, enter the total noncovered days by the primary payer. The sum of covered days and noncovered days must equal the number of days in the "From-Through" period in Form Locator 6.

- **Personal Care Services –** ForwardHealth topic #2479
  For personal care and travel time, one unit of service is equal to 15 minutes. When calculating the number of units that should be submitted, total or combine the number of personal care hours or travel time hours for the DOS. Each DOS should have 1 line entered for PCW and 1 line for travel time, if applicable.

  Example of Claim submissions:

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
	INCORRECT BILLING;					
0570	PCW SERVICE	T1019	121417	9	36.18	
0570	PCW SERVICE	T1019	121417	4	16.08	
	CORRECT BILLING;					
0570	PCW SERVICE	T1019	121417	13	52.26	

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

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
	INCORRECT BILLING;					
0570	PCW SERVICE	T1019 U3	121417	1	4.02	
0570	PCW SERVICE	T1019 U3	121417	1	4.02	
0570	PCW SERVICE	T1019 U3	121417	1	4.02	
	CORRECT BILLING;					
0570	PCW SERVICE	T1019 U3	121417	3	12.06	

Annual Notice of Member Rights and Responsibilities

What are our Members Rights and Responsibilities?
These rights and responsibilities are on the Molina Healthcare web site: MolinaHealthcare.com.

Their Rights
They have the right to:

- Be treated with respect and recognition of their dignity by everyone who works with Molina.
- Get information about Molina, our providers, our doctors, our services and Members' rights and responsibilities.
- Choose their "main" doctor from Molina's list of Participating Providers (This doctor is called their Primary Care Doctor or Personal Doctor).
- Be informed about their health. If they have an illness, they have the right to be told about all treatment options regardless of cost or benefit coverage. They have the right to have all their questions about their health answered.
- Help make decisions about their health care. They have the right to refuse medical treatment.
- They have a right to Privacy. We keep their medical records private.*
- See their medical record. They also have the right to get a copy of and correct their medical record where legally allowed.*
- Complain about Molina or their care. They can call, fax, e-mail or write to Molina's Customer Support Center.
- Appeal Molina's decisions. They have the right to have someone speak for them during their grievance.
- Disenroll from Molina (leave the Molina Healthcare product).
- Ask for a second opinion about their health condition.
- Ask for someone outside Molina to look into therapies that are Experimental or Investigational.
- Decide in advance how they want to be cared for in case they have a life-threatening illness or injury.
- Get interpreter services on a 24 hour basis at no cost to help them talk with their doctor or us if they prefer to speak a language other than English.
- Get information about Molina, their providers, or their health in the language they prefer.
- Ask for and get materials in other formats such as, larger size print, audio and Braille upon request and in a timely fashion appropriate for the format being requested and in accordance with state laws.
- Receive instructions on how they can view online, or request a copy of, Molina's non-proprietary clinical and administrative policies and procedures.
- Get a copy of Molina's list of approved drugs (Drug Formulary) on request.
- Submit a grievance if they do not get Medically Necessary medications after an Emergency visit at one of Molina's contracted hospitals.
- Not to be treated poorly by Molina or their doctors for acting on any of these rights.
- Make recommendations regarding Molina's Member rights and responsibilities policies.
- Be free from controls or isolation used to pressure, punish or seek revenge.
- File a grievance or complaint if they believe their linguistic needs were not met by Molina.*Subject to State and Federal laws.

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Their Responsibilities

They have the responsibility to:

- Learn and ask questions about their health benefits. If they have a question about their benefits, call toll-free at (888) 560-2043. If they are deaf or hard of hearing, they may contact us by dialing 7-1-1 for the National Relay Service.
- Give information to their doctor, provider, or Molina that is needed to care for them.
- Be active in decisions about their health care.
- Follow the care plans for them that they have agreed on with their doctor(s).
- Build and keep a strong patient-doctor relationship. Cooperate with their doctor and staff. Keep appointments and be on time. If they are going to be late or cannot keep their appointment, they must call their doctor's office.
- Give their Molina Healthcare card when getting medical care. Do not give their card to others. Let Molina know about any fraud or wrong doing.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals as they are able.

Be Active In Their Healthcare

Plan Ahead

- Schedule their appointments at a good time for them.
- Ask for their appointment at a time when the office is least busy if they are worried about waiting too long.
- Keep a list of questions they want to ask their doctor.
- Refill their prescription before they run out of medicine.

Make the Most of Doctor Visits

- Ask their doctor questions.
- Ask about possible side effects of any medication prescribed.
- Tell their doctor if they are drinking any teas or taking herbs. Also tell their doctor about any vitamins or over–the-counter medications they are using.

Visiting Their Doctor When They are Sick

- Try to give their doctor as much information as they can.
- Are they getting worse or are their symptoms staying about the same?
- Have they taken anything?

If they would like more information, please call Molina's Customer Support Center toll-free at (888) 560-2043, Monday through Friday, between 8:00 a.m. and 5:00 p.m. CT. If they are deaf or hard of hearing, they may contact us by dialing 7-1-1 for the National Relay Service.

Second Opinions

If a member does not agree with their provider's plan of care, they have the right to request a second opinion from another provider. Members should call Member Services to find out how to get a second opinion. Second opinions may require Prior Authorization.

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Provider Services
11200 W. Parkland Avenue
Milwaukee, WI 53224

MolinaHealthcare.com

Your Extended Family.

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