It Matters to Molina: Home Health Authorization Reconsideration Process and Best Practices

2022 | Molina Healthcare

MOLINA HEALTHCARE

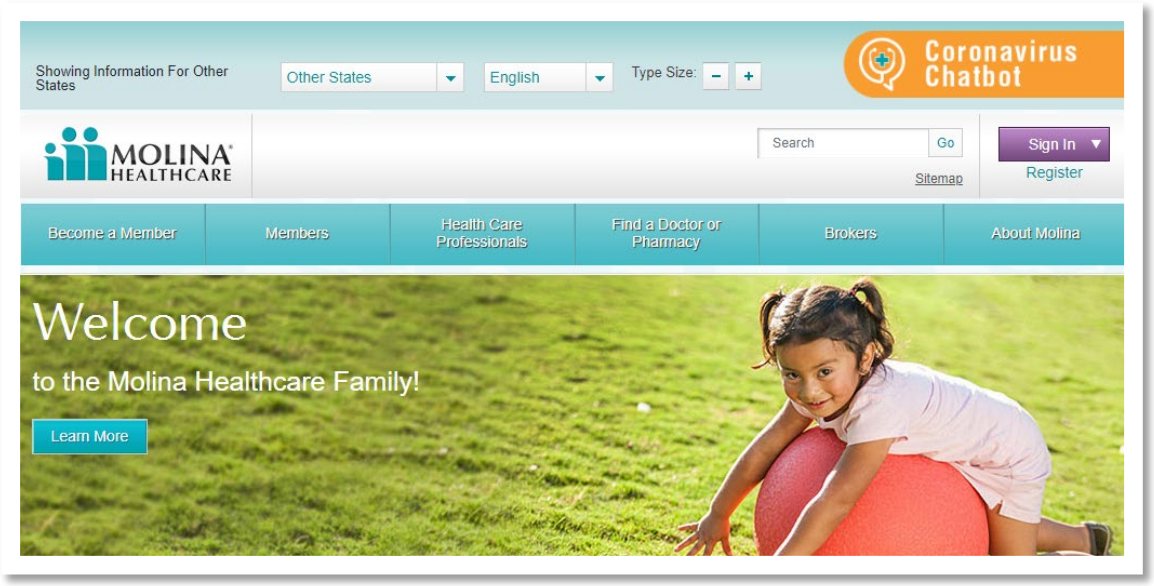
Agenda

- Provider Resources
- Molina Provider Portal and Availity
- Home Health Prior Authorization
- Authorization Reconsideration Process
- Home Health Authorization Reconsideration
- Contact Molina

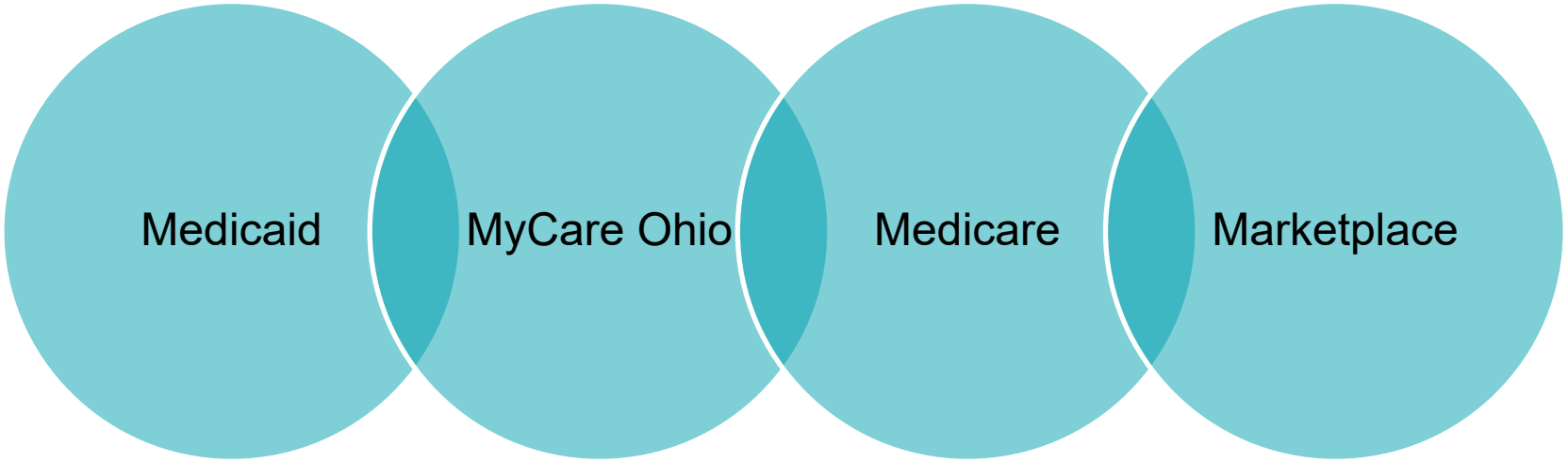
Provider Resources

MOLINA HEALTHCARE

Provider Website



Molina has a Provider Website for each line of business.



Find the Provider Website at MolinaHealthcare.com.

Provider Online Resources

Molina's Provider Website has a variety of online resources:

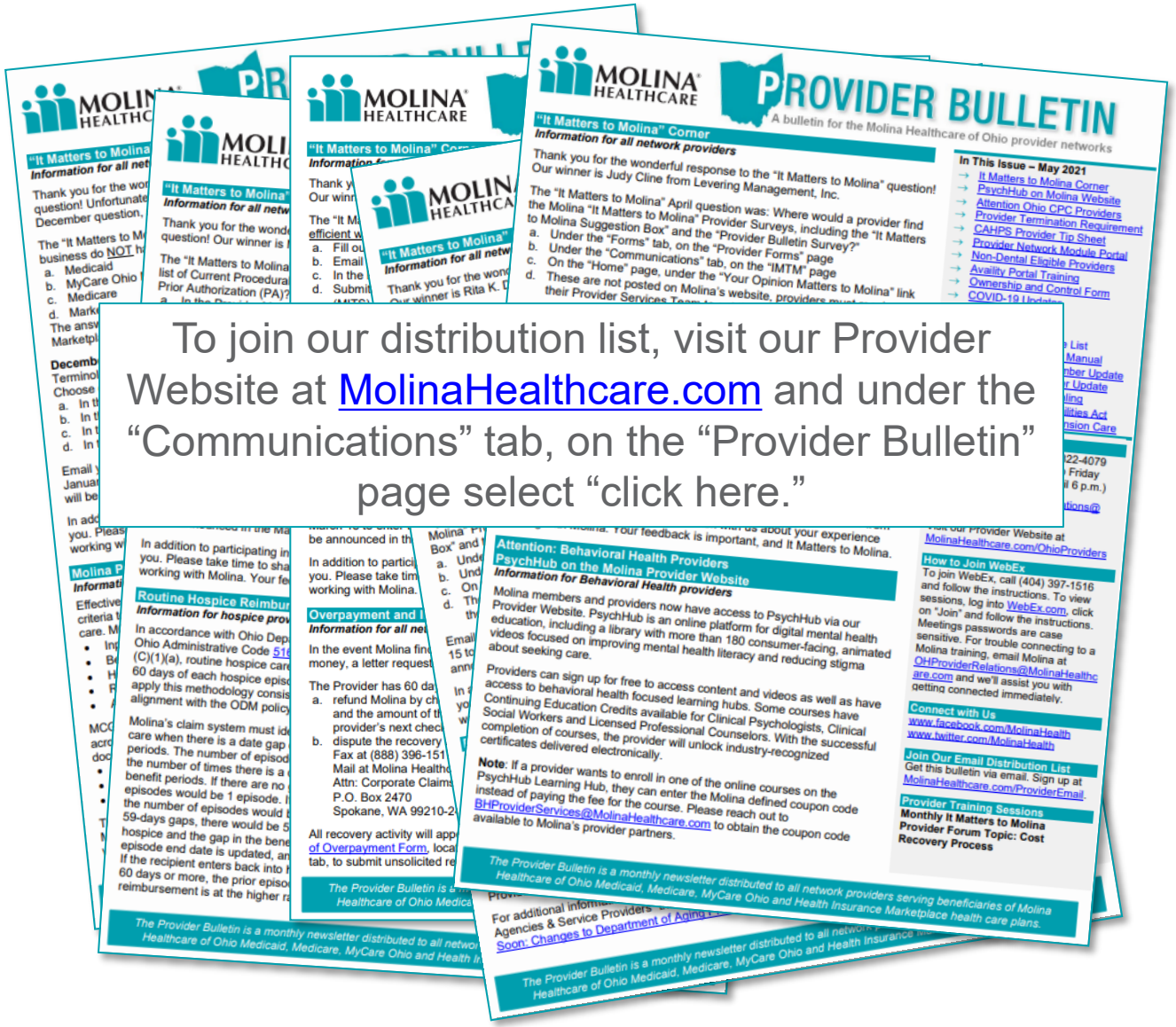
- Provider Manual
- Dental Manual
- Provider Portal
- It Matters to Molina Page and a Claims Payment Systemic Errors (CPSE) Page
- Provider Online Directory
- Contact Information
- Preventive and Clinical Care Guidelines
- Claims Information
- Health Insurance Portability and Accountability Act (HIPAA)
- Advanced Directives
- Frequently Used Forms
- Pharmacy Information
- Prior Authorization Information
- Claim Reconsiderations
- Provider Communications: Provider Bulletins and Provider Newsletters
- Fraud, Waste and Abuse Information
- Member Rights and Responsibilities
- Molina Policies

Provider Bulletin

A monthly Provider Bulletin is sent to Molina's provider network to report updates.

The Provider Bulletin includes:

- Prior authorization changes
- Training opportunities
- Updates to the Provider Portal
- It Matters to Molina Corner
- Changes in policies that could affect:
  - Claim submissions
  - Billing procedures
  - Payment
  - Appeals



To join our distribution list, visit our Provider Website at MolinaHealthcare.com and under the "Communications" tab, on the "Provider Bulletin" page select "click here."

Molina Provider Portal and Availity

MOLINA HEALTHCARE

Provider Portal: Transition from Molina Provider Portal to Availity

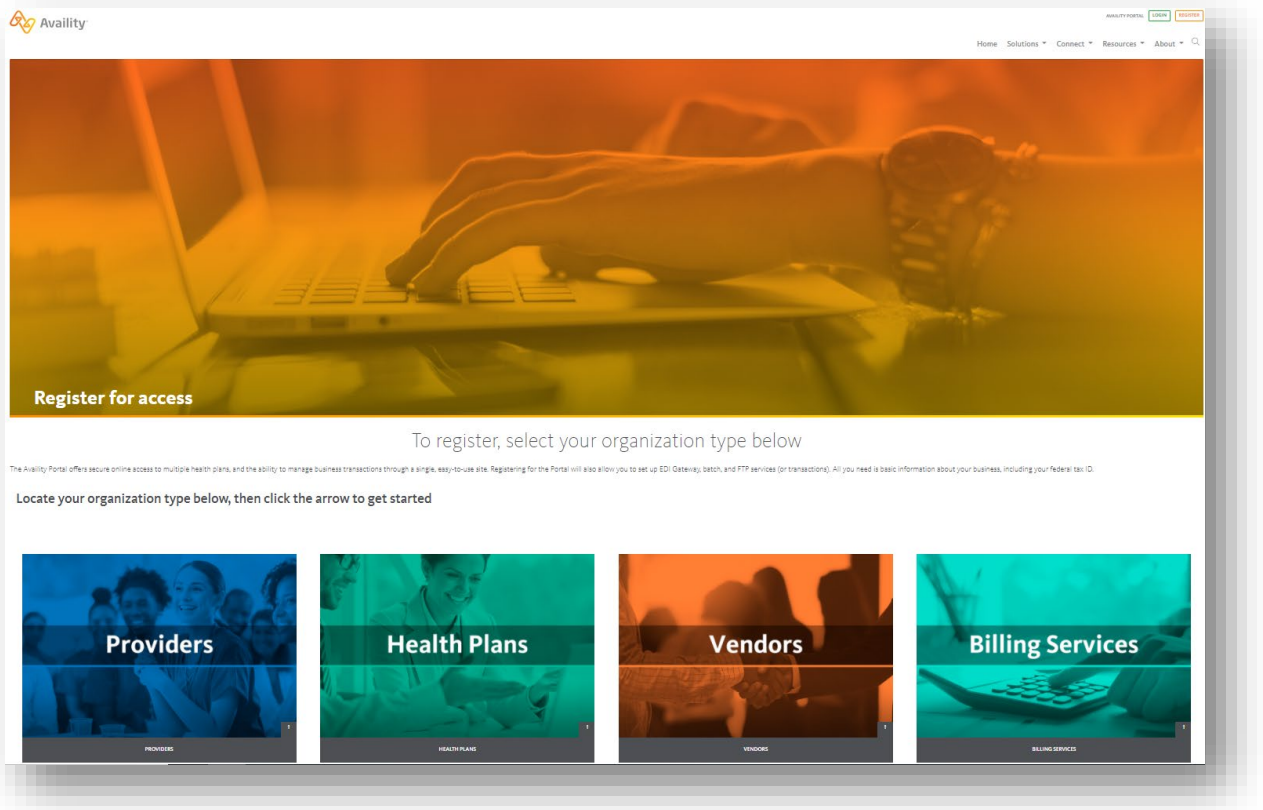
Availity is Molina's exclusive Provider Portal provider.

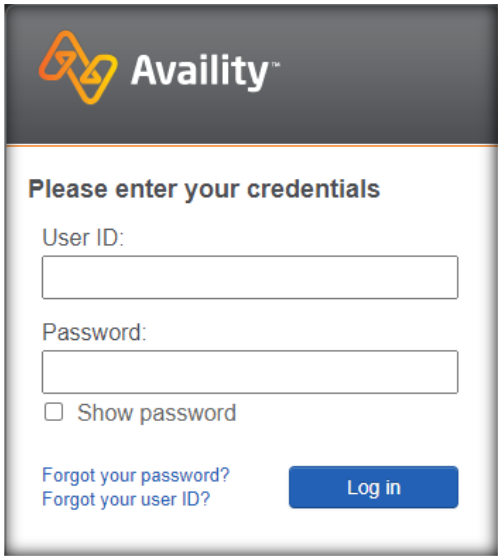
- The Molina Provider Portal, including all features, functionality, and resources will continue transitioning to Availity in 2022.
- This is a phased transition, with access to both the Molina Provider Portal and the Availity Portal being available via single sign-on as features and functionality are deployed on the Availity Portal.
- Features currently available on the Availity Portal include submitting new claims, correcting claims, accessing claims reports and claim status, adding attachments, eligibility verification, secure messaging with Molina, and Electronic Remittance Advice (ERA).

Providers should register for the Provider Portal at Availity.com.

Availity Provider Portal

Register for Availity at availity.com/provider-portal-registration and select your organization type.

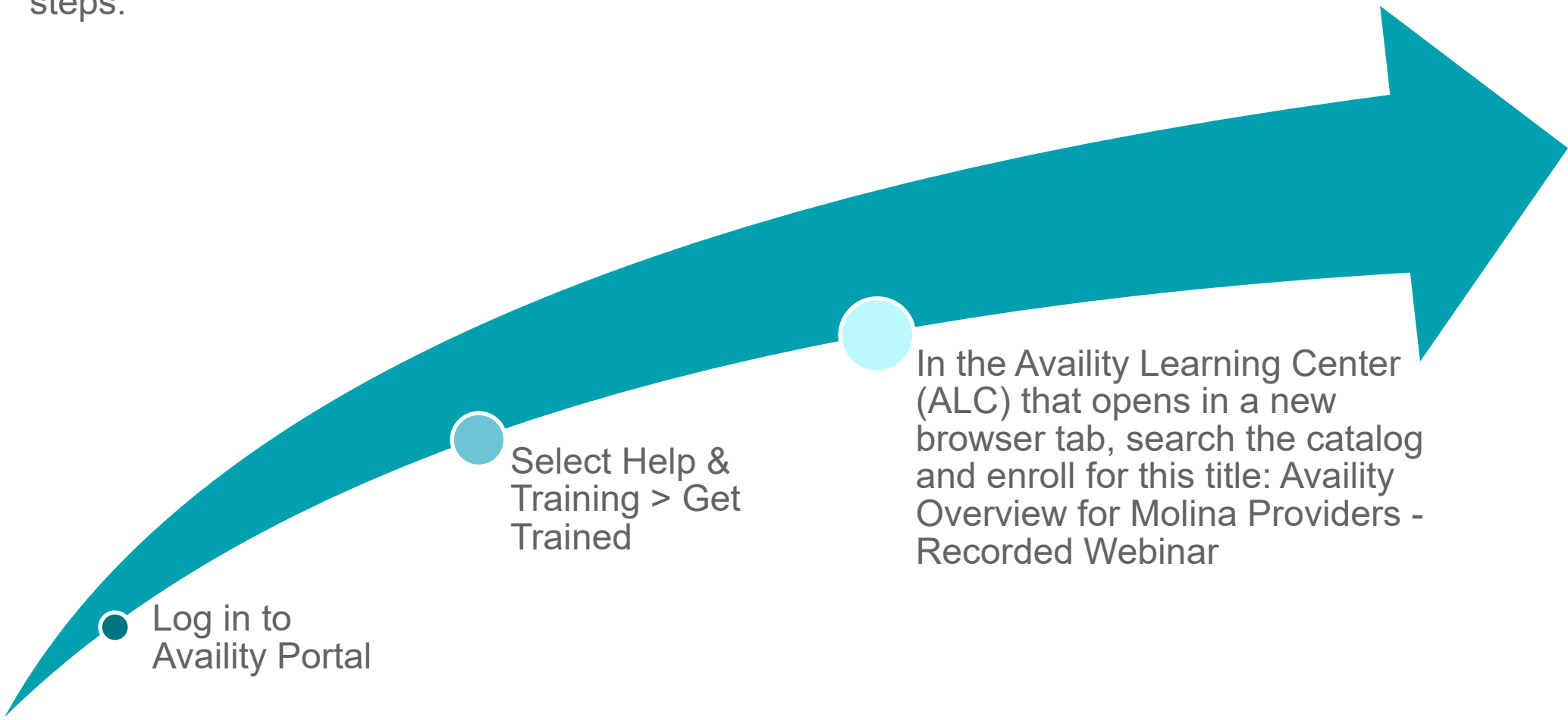




Log into Availity at:
apps.availity.com/availity/web/public.elegant.login.

Availity Provider Portal

Once registered providers will have access to the Availity Portal training by following these steps:



Atypical Providers:
Under “News and Announcements” select “Atypical Providers: Here’s your Ticket to Working with the Availity Portal” to view training sessions.

Provider Portal

The Provider Portal is secure and available 24 hours a day, seven days a week. Self-service Provider Portal options include:

- Online Claim Submission
- Claims Status Inquiry
- Corrected Claims
- Healthcare Effectiveness Data and Information Set (HEDIS®) Missed Service Alerts for Members
- Member Eligibility Verification and History
- Update Provider Profile
- Online Claim Reconsideration Requests
- Member Nurse Advice Line Call Reports
- Check Status of Authorization Request
- Coordination of Benefits (COB)
- View PCP Member Roster
- Submit PA Requests

Home Health Prior Authorization

MOLINA HEALTHCARE

Prior Authorization (PA)

Prior Authorization (PA) is a request for prospective review. Requests for services on the Molina PA Code List are evaluated by licensed nurses and trained staff.

PA is designed to:				
Assist in benefit determination	Prevent unanticipated denials of coverage	Create a collaborative approach to determining the appropriate level of care	Identify care management and disease management opportunities	Improve coordination of care

The PA Code List is a list of the services that require a provider to submit a PA request and if there are limitations to the code.

View the PA Code List on our Provider Website, under the “Forms” tab

Utilize the PA Lookup Tool on our Provider Website and Provider Portal to determine if a PA is required

Prior Authorization Basics

Molina understands that an efficient PA process is important to our providers. These quick tips for requesting a home health PA will help make sure that Molina receives all of the information needed to process your requests as quickly as possible so that you can focus on what's most important, providing care to your patients.

This basic information is needed on all PA requests for home health services:

- Check the patient's insurance information to make sure that Molina is the primary insurer
- Complete the Molina PA Request Form or the Ohio Care Coordination Plan Standardized PA Request Form
- Submit all information required for home health services

For additional information view the Home Health Prior Authorization Request Quick Tips on our Provider Website.

Prior Authorization Start of Care Only

Documentation of a face-to-face encounter with the treating physician within 90 days prior to the start of care date, or within 30 days following the start of care date

A current completed Outcome and Assessment Information Set (OASIS)/ 485

Completion of a Certificate of Medical Necessity for Home Health Services Form (ODM 07137)

Prior Authorization Start of Care & Continuing Care Requests

Supporting documentation of the patient's need for home health services.

A current completed OASIS or 485.

Date of last face-to-face encounter with physician.

Written physician's order for continuing home health services from the attending physician actively treating the patient.

All home health requests require ongoing supervision by the treating physician. The treating physician must order recertification and document the clinical need for continuation of services.

Prior Authorization Clinical Information

- Current diagnosis and co-morbidities
- Current medical status
- Medication list and compliance
- Recent hospitalization information
- Latest 485 form

Molina responds to routine home health service requests within 10 days

- Durable Medical Equipment (DME) currently utilized
- If requested home health nurse visit, indicate the specific skilled nursing need to support the request
- Provide a complete description of any wounds: size, depth, type, and frequency of dressings
- Daily home health notes for the last two weeks of the most recent skilled nursing visit and/or home health aide notes (therapy progress notes if applicable)

Home Health Review Process

Molina's home health services review process ensures that clinically appropriate decisions are made utilizing medically necessary evidence to uphold the decisions, including:

- Review of current comprehensive member clinical information, including obtainment of necessary clinical documentation
- If member has Medicaid, MyCare Ohio, Medicare or Marketplace coverage
- Applicable State of Ohio laws, regulations, rules, and guidance
- Use of a personal care service screening and calculation tool, which can be utilized telephonically and/or face-to-face
- Nationally recognized evidence-based guidelines and third-party guidelines
- Advice from authoritative review articles and textbooks

Molina Prior Authorization Request Form

Molina Prior Authorization (PA) Request Form	MyCare Ohio Uniform Authorization Request Form
• Molina recommends providers in all lines of business utilize the Molina PA Request Form • The PA Request Form includes fax resources per line of business/service type • The PA Request Form is available on the Molina Provider Website	• The MyCare Ohio Managed Care Plans allow providers to use a single Uniform Authorization Request Form regardless of which company is managing the patient • This form is to be used only with the MyCare Ohio plan • The Uniform Authorization Request Form is available on the Molina Provider Website

Authorization Reconsideration Process

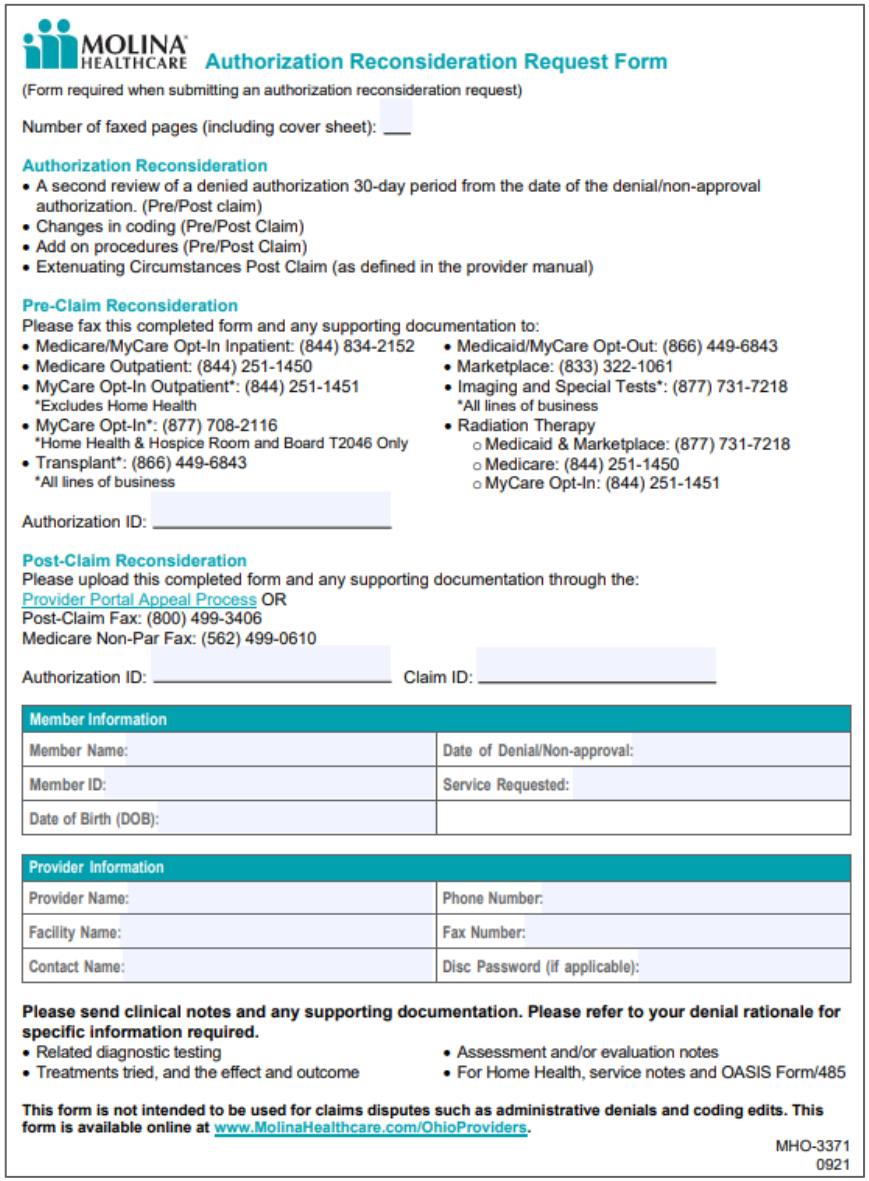
MOLINA HEALTHCARE

Authorization Reconsiderations

An Authorization Reconsideration is a request by a provider or facility to review and possibly change a denied services to an approval of services, based on the submission of **new or additional** information.

The Authorization Reconsideration Form is available on the Molina Provider Website.

Reminder: An Authorization Reconsideration request can be submitted within 30 calendar days of the date on the denial letter.



MOLINA HEALTHCARE

Authorization Reconsideration Request Form

(Form required when submitting an authorization reconsideration request)

Number of faxed pages (including cover sheet): ___

Authorization Reconsideration

- A second review of a denied authorization 30-day period from the date of the denial/non-approval authorization. (Pre/Post claim)
- Changes in coding (Pre/Post Claim)
- Add on procedures (Pre/Post Claim)
- Extenuating Circumstances Post Claim (as defined in the provider manual)

Pre-Claim Reconsideration

Please fax this completed form and any supporting documentation to:

- Medicare/MyCare Opt-In Inpatient: (844) 834-2152
- Medicare Outpatient: (844) 251-1450
- MyCare Opt-In Outpatient*: (844) 251-1451
  *Excludes Home Health
- MyCare Opt-In*: (877) 708-2116
  *Home Health & Hospice Room and Board T2046 Only
- Transplant*: (866) 449-6843
  *All lines of business
- Medicaid/MyCare Opt-Out: (866) 449-6843
- Marketplace: (833) 322-1061
- Imaging and Special Tests*: (877) 731-7218
  *All lines of business
- Radiation Therapy
  - Medicaid & Marketplace: (877) 731-7218
  - Medicare: (844) 251-1450
  - MyCare Opt-In: (844) 251-1451

Authorization ID: _____

Post-Claim Reconsideration

Please upload this completed form and any supporting documentation through the:
Provider Portal Appeal Process OR
Post-Claim Fax: (800) 499-3406
Medicare Non-Par Fax: (562) 499-0610

Authorization ID: _____ Claim ID: _____

Member Information	
Member Name:	Date of Denial/Non-approval:
Member ID:	Service Requested:
Date of Birth (DOB):	

Provider Information	
Provider Name:	Phone Number:
Facility Name:	Fax Number:
Contact Name:	Disc Password (if applicable):

Please send clinical notes and any supporting documentation. Please refer to your denial rationale for specific information required.

- Related diagnostic testing
- Treatments tried, and the effect and outcome
- Assessment and/or evaluation notes
- For Home Health, service notes and OASIS Form/485

This form is not intended to be used for claims disputes such as administrative denials and coding edits. This form is available online at www.MolinaHealthcare.com/OhioProviders.

MHO-3371
0921

Authorization Reconsiderations: Medicaid and Marketplace

Pre-Service and Post-Service Authorization Reconsiderations Recourses:

You can ask for one Member Appeal represented by the provider

A member appeal can be requested within 60 calendar days of the date on the authorization denial letter. If your patient wants you to appeal on their behalf, your patient must tell us this in writing using the Authorized Representative Form posted on the Molina Provider Website.

You can ask for one Authorization Reconsideration

An Authorization Reconsideration can be submitted within 30 calendar days of the date on the authorization denial letter. Requests may be submitted whether a Peer-to-Peer is requested or not.

- Requests may be submitted through the Provider Portal or fax

You can ask for one Peer-to-Peer Review

The treating provider can request a Peer-to-Peer Review with the physician reviewer within 5 calendar days of the date on the authorization denial letter.

- Call Molina Utilization Management at (855) 322-4079 from 8:30 a.m. to 5 p.m., Monday to Friday.
- Include 2 possible dates and times a licensed professional is available to conduct the review with a Molina Medical Director.

Authorization Reconsiderations: Medicare and MyCare Ohio

Pre-Service and Post-Service Authorization Reconsiderations Recourses:

Molina **Medicare and MyCare Ohio** Provider recourses for a non-approved/denied authorization request.

You can ask for one Peer-to-Peer Review

- The treating provider can request a Peer-to-Peer Review with the physician reviewer within 5 calendar days of the date on the authorization non-approval/denial letter, or up to the date of discharge.
- Call Molina Utilization Management at (855) 322-4079 from 8:30 a.m. to 5 p.m., Monday to Friday.
- Include 2 possible dates and times a licensed professional is available to conduct the review with a Molina Medical Director.

Note: Due to regulatory requirements, for Outpatient decisions a Peer-to-Peer is a consultation only, a determination cannot be overturned.

Authorization Reconsiderations: Medicare and MyCare Ohio

Pre-Service and Post-Service Authorization Reconsiderations Recourses:

Molina **Medicare and MyCare Ohio** Provider recourses for a non-approved/denied authorization request.

You can ask for one Member Appeal represented by the provider

- A member appeal can be requested within 60 calendar days of the date on the authorization denial letter.
- If your patient wants you to appeal on their behalf, your patient must tell us this in writing using the Authorized Representative Form posted at MolinaHealthcare.com/OhioProviders.

Authorization Reconsiderations Quick Reference Guide

The grid below summarizes your options by type of authorization by line of business.

	Outpatient			Inpatient		
	Peer-to-Peer	Authorization Reconsideration	Provider Rep. Member Appeal	Peer-to-Peer	Authorization Reconsideration	Provider Rep. Member Appeal
Medicaid/ Marketplace	Yes	Yes	Yes	Yes	Yes	Yes
Medicare/ MyCare Ohio	Yes*	No	Yes	Yes	Yes	Yes

*As noted in the slide above, due to regulatory requirements, for Outpatient decisions a Peer-to-Peer is a consultation only, a determination cannot be overturned.

Note: Providers are limited to one Authorization Reconsideration request per service request

Molina strongly encourages providers to submit an Authorization Reconsideration request prior to submitting an appeal.

Authorization Reconsideration Guides

Molina published the following guides to help break down the differences between a Peer-to-Peer review, an Authorization Reconsideration, a Claim Reconsideration, and a Member Appeal represented by the provider

- Medicaid and Marketplace Authorization and Claim Reconsideration Guide
- MyCare Ohio and Medicare Authorization and Claim Reconsideration Guide

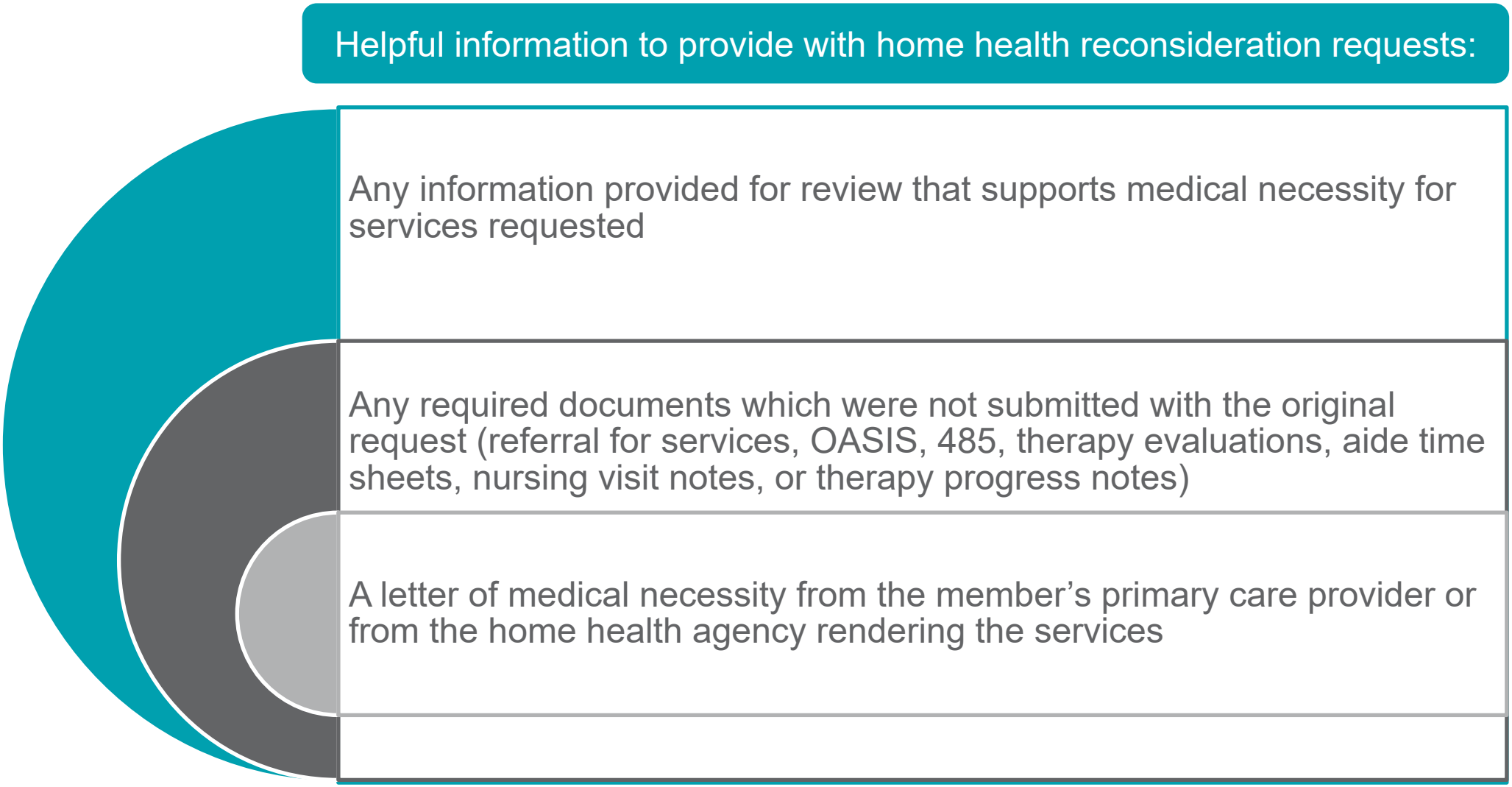
- These guides are specific to each line of business
- Providers should confirm the line of business the member is eligible under, and reference the correct guide
- The requirements for each process are included inside the document

For more information regarding our Authorization Reconsideration process please see the reference guides on the Provider Website on the “Manual Tab” on the Quick Reference Guides & FAQs page.

Home Health Authorization Reconsideration Helpful Information

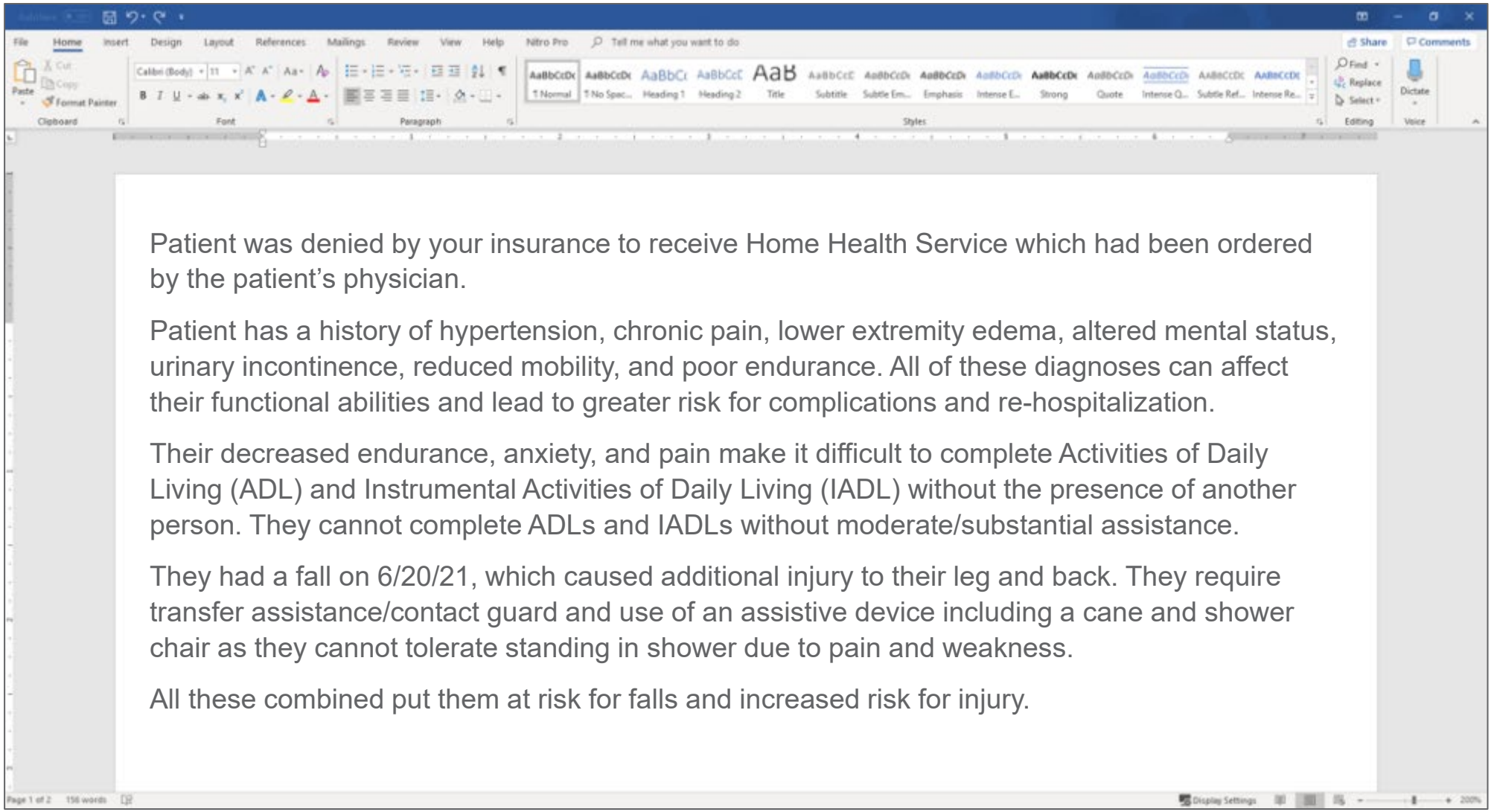
MOLINA HEALTHCARE

Home Health Authorization Reconsideration Requests



Supporting Medical Necessity

Example of information to support medical necessity for services requested:



Patient was denied by your insurance to receive Home Health Service which had been ordered by the patient's physician.

Patient has a history of hypertension, chronic pain, lower extremity edema, altered mental status, urinary incontinence, reduced mobility, and poor endurance. All of these diagnoses can affect their functional abilities and lead to greater risk for complications and re-hospitalization.

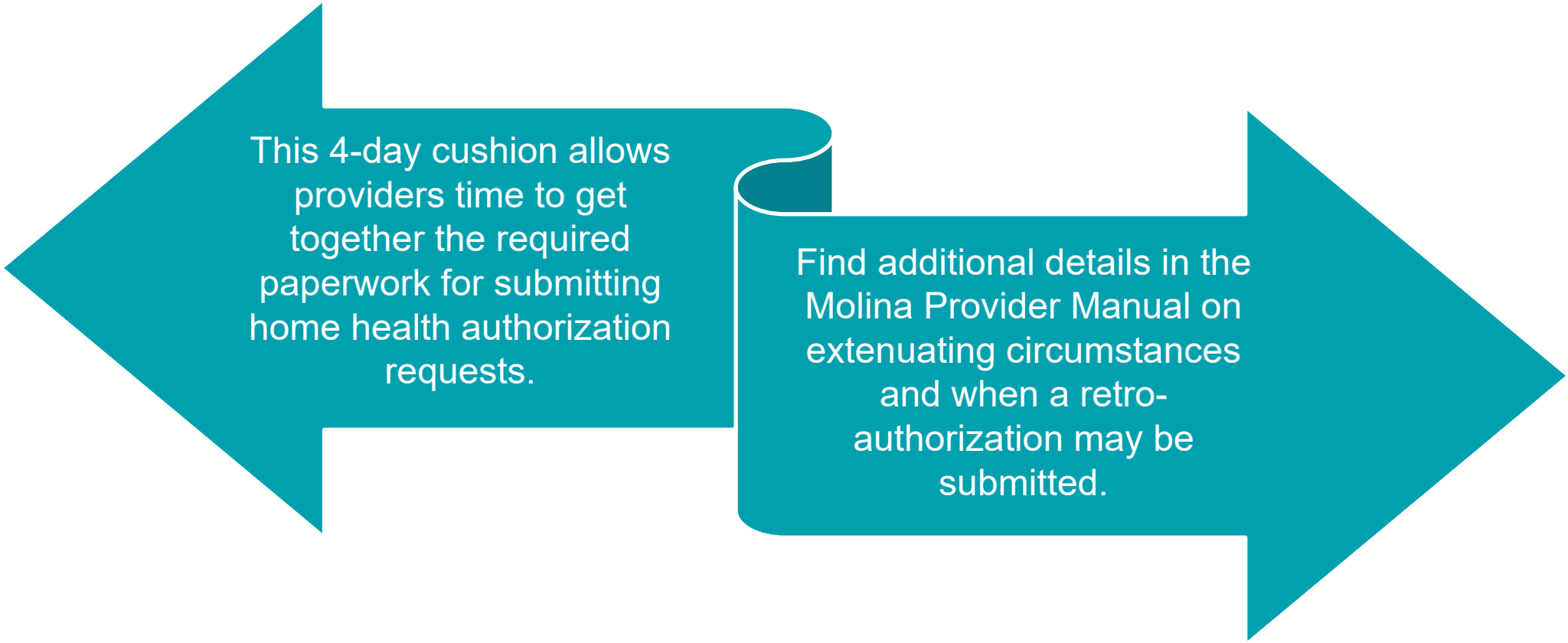
Their decreased endurance, anxiety, and pain make it difficult to complete Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) without the presence of another person. They cannot complete ADLs and IADLs without moderate/substantial assistance.

They had a fall on 6/20/21, which caused additional injury to their leg and back. They require transfer assistance/contact guard and use of an assistive device including a cane and shower chair as they cannot tolerate standing in shower due to pain and weakness.

All these combined put them at risk for falls and increased risk for injury.

Home Health Four-Day Retro-Authorization Allowable

Molina allows a medical necessity review for home health services up to four days prior to the date of the submitted PA Request.



Contact Molina

MOLINA HEALTHCARE

Frequently Used Email Addresses

Molina of Ohio Provider Services Contact Information:

Molina has designated email addresses based on provider types to help get your questions answered more efficiently or to connect you to training opportunities.

- **MyCare Ohio LTSS and Medicaid Ancillary questions**: OHMyCareLTSS@MolinaHealthcare.com
  Note: Home Health providers should utilize the OHMyCareLTSS@MolinaHealthcare.com email address

- Behavioral Health questions: BHProviderServices@MolinaHealthcare.com
- Hospital or hospital-affiliated physician group questions: OHProviderServicesHospital@MolinaHealthcare.com
- Nursing Facilities questions: OHProviderServicesNF@MolinaHealthcare.com
- Physician practice questions: OHProviderServicesPhysician@MolinaHealthcare.com
- General questions: OHProviderRelations@MolinaHealthcare.com

For additional contact information view the “Contact Information” section of the Provider Manual, located at MolinaHealthcare.com.

Molina Provider Training Survey

The Molina Provider Services Team hopes you have found this training session beneficial.

It Matters TO MOLINA

Please take a few minutes to complete the Molina Provider Training survey to provide feedback on this session.

The survey is located on the It Matters to Molina Page of our Provider Website, under the "Communications" tab.

Molina wants to hear about what other topics you'd like training on in the future.

MOLINA HEALTHCARE

Please share your feedback with us so we can continue to provide you with excellent customer service!