OAMES Seminar

2020 | Molina Healthcare of Ohio

MOLINA HEALTHCARE

Commitment to Provider Satisfaction

Molina Healthcare of Ohio is committed to increasing our Provider Partners' satisfaction by obtaining your feedback.

Some of the ways we do this include:

- Dedicated Provider Services Representatives in each region of the state for training and questions
- An annual Provider Satisfaction Survey
- It Matters to Molina online survey
- Provider Forums

It Matters TO MOLINA®

Your Opinion Matters to Molina

Email us to share your comments, concerns or ideas. Your feedback is important to us. Let us know what we're doing well and what we can do to improve.

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

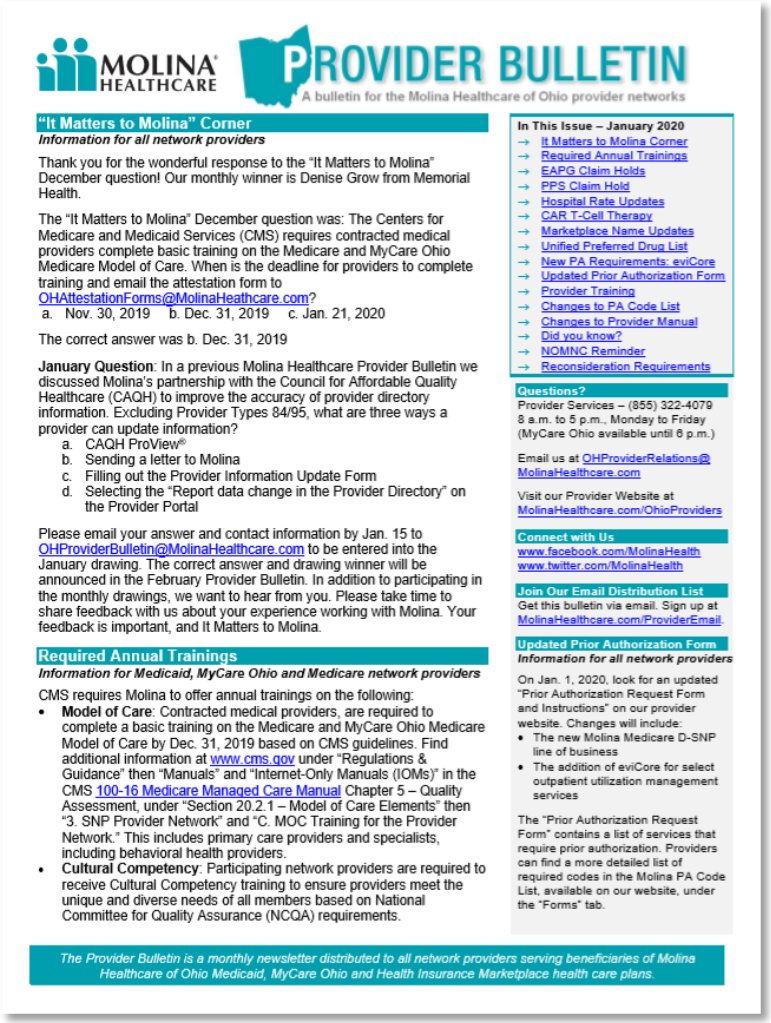
Provider Bulletin

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

The Provider Bulletin includes:

Information for providers in all networks

- Prior authorization changes
- Provider training opportunities
- Changes in policies that could effect claim submission, billing procedures or appeals
- Updates to the Molina Healthcare Provider Portal



MOLINA HEALTHCARE

PROVIDER BULLETIN

A bulletin for the Molina Healthcare of Ohio provider networks

"It Matters to Molina" Corner

Information for all network providers

Thank you for the wonderful response to the "It Matters to Molina" December question! Our monthly winner is Denise Grow from Memorial Health.

The "It Matters to Molina" December question was: The Centers for Medicare and Medicaid Services (CMS) requires contracted medical providers complete basic training on the Medicare and MyCare Ohio Medicare Model of Care. When is the deadline for providers to complete training and email the attestation form to OHAttestationForms@MolinaHealthcare.com?

a. Nov. 30, 2019 b. Dec. 31, 2019 c. Jan. 21, 2020

The correct answer was b. Dec. 31, 2019

January Question: In a previous Molina Healthcare Provider Bulletin we discussed Molina's partnership with the Council for Affordable Quality Healthcare (CAQH) to improve the accuracy of provider directory information. Excluding Provider Types 84/95, what are three ways a provider can update information?

a. CAQH ProView®
b. Sending a letter to Molina
c. Filling out the Provider Information Update Form
d. Selecting the "Report data change in the Provider Directory" on the Provider Portal

Please email your answer and contact information by Jan. 15 to OHProviderBulletin@MolinaHealthcare.com to be entered into the January drawing. The correct answer and drawing winner will be announced in the February Provider Bulletin. In addition to participating in the monthly drawings, we want to hear from you. Please take time to share feedback with us about your experience working with Molina. Your feedback is important, and It Matters to Molina.

Required Annual Trainings

Information for Medicaid, MyCare Ohio and Medicare network providers

CMS requires Molina to offer annual trainings on the following:

- **Model of Care**: Contracted medical providers, are required to complete a basic training on the Medicare and MyCare Ohio Medicare Model of Care by Dec. 31, 2019 based on CMS guidelines. Find additional information at www.cms.gov under "Regulations & Guidance" then "Manuals" and "Internet-Only Manuals (IOMs)" in the CMS 100-16 Medicare Managed Care Manual Chapter 5 – Quality Assessment, under "Section 20.2.1 – Model of Care Elements" then "3. SNP Provider Network" and "C. MOC Training for the Provider Network." This includes primary care providers and specialists, including behavioral health providers.
- **Cultural Competency**: Participating network providers are required to receive Cultural Competency training to ensure providers meet the unique and diverse needs of all members based on National Committee for Quality Assurance (NCQA) requirements.

In This Issue – January 2020

- It Matters to Molina Corner
- Required Annual Trainings
- EAPG Claim Holds
- PPS Claim Hold
- Hospital Rate Updates
- CAR T-Cell Therapy
- Marketplace Name Updates
- Unified Preferred Drug List
- New PA Requirements: eviCore
- Updated Prior Authorization Form
- Provider Training
- Changes to PA Code List
- Changes to Provider Manual
- Did you know?
- NOMNC Reminder
- Reconsideration Requirements

Questions?

Provider Services – (855) 322-4079
8 a.m. to 5 p.m., Monday to Friday
(MyCare Ohio available until 6 p.m.)

Email us at OHProviderRelations@MolinaHealthcare.com

Visit our Provider Website at MolinaHealthcare.com/OhioProviders

Connect with Us

www.facebook.com/MolinaHealth
www.twitter.com/MolinaHealth

Join Our Email Distribution List

Get this bulletin via email. Sign up at MolinaHealthcare.com/ProviderEmail.

Updated Prior Authorization Form

Information for all network providers

On Jan. 1, 2020, look for an updated "Prior Authorization Request Form and Instructions" on our provider website. Changes will include:

- The new Molina Medicare D-SNP line of business
- The addition of eviCore for select outpatient utilization management services

The "Prior Authorization Request Form" contains a list of services that require prior authorization. Providers can find a more detailed list of required codes in the Molina PA Code List, available on our website, under the "Forms" tab.

The Provider Bulletin is a monthly newsletter distributed to all network providers serving beneficiaries of Molina Healthcare of Ohio Medicaid, MyCare Ohio and Health Insurance Marketplace health care plans.

It Matters TO MOLINA®

Molina Healthcare of Ohio offers your office the opportunity to be entered into a monthly drawing for a prize! To enter, follow the "It Matters to Molina" Corner article instructions found in our monthly Provider Bulletin.

Visit our website at www.MolinaHealthcare.com/OhioProviders to join our distribution list.

Molina's Provider Portal

The Provider Portal is secure and available 24 hours a day, seven days a week. Register for access to our Provider Portal for self-services, including:

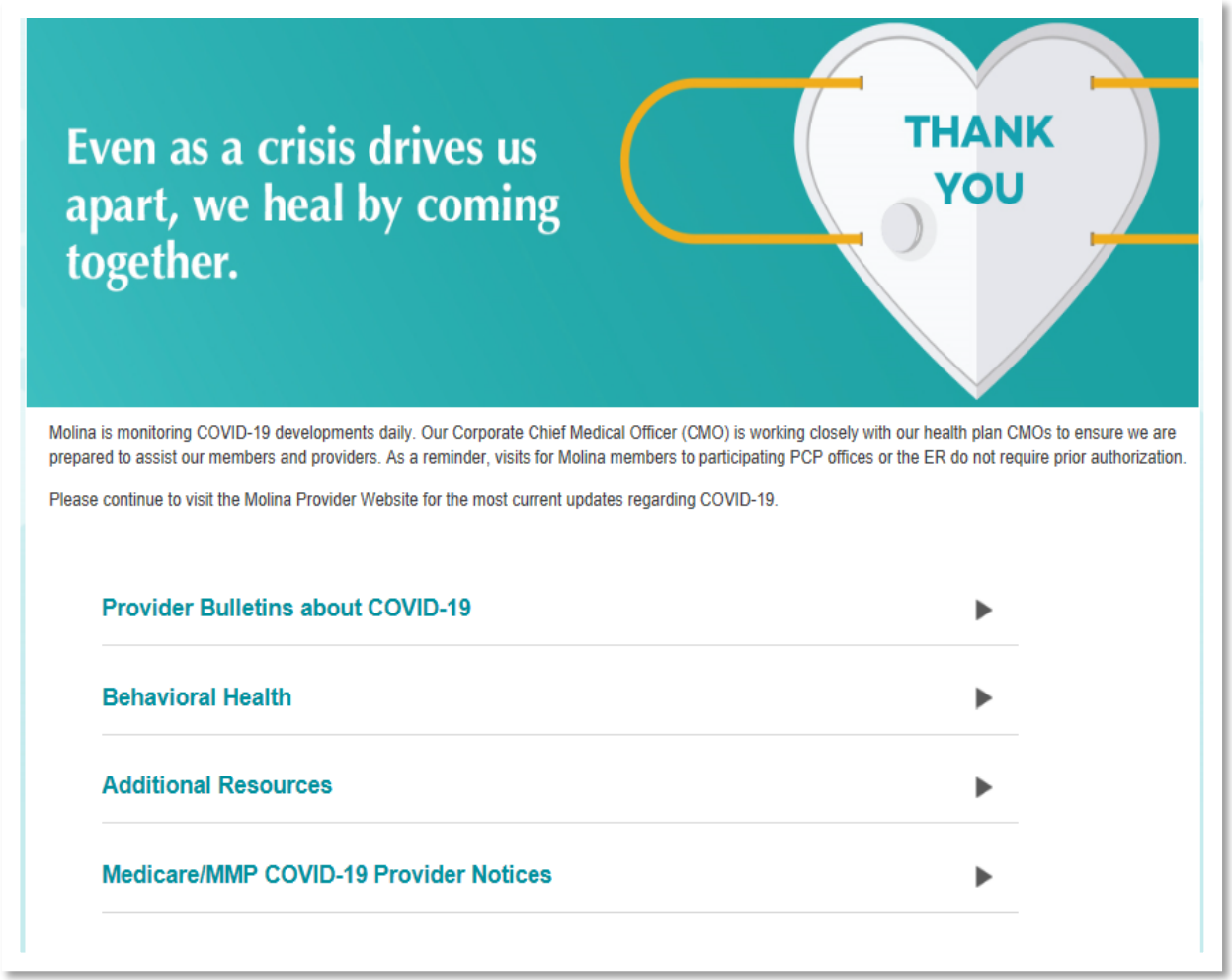
Provider Portal Claim Features	
• Submit professional claims	• Submit facility claims
• Online claim reconsideration	• Void a claim
• Submit a corrected claim	• Save claims for batch submission
• Check the status of a claim	• Export claims to Excel
• Create a claims template	• Add supporting documents to your claim

Self-service tools are available on the Provider Portal.
Register online at https://eportal.molinahealthcare.com/Provider/login.

COVID-19 (Coronavirus)

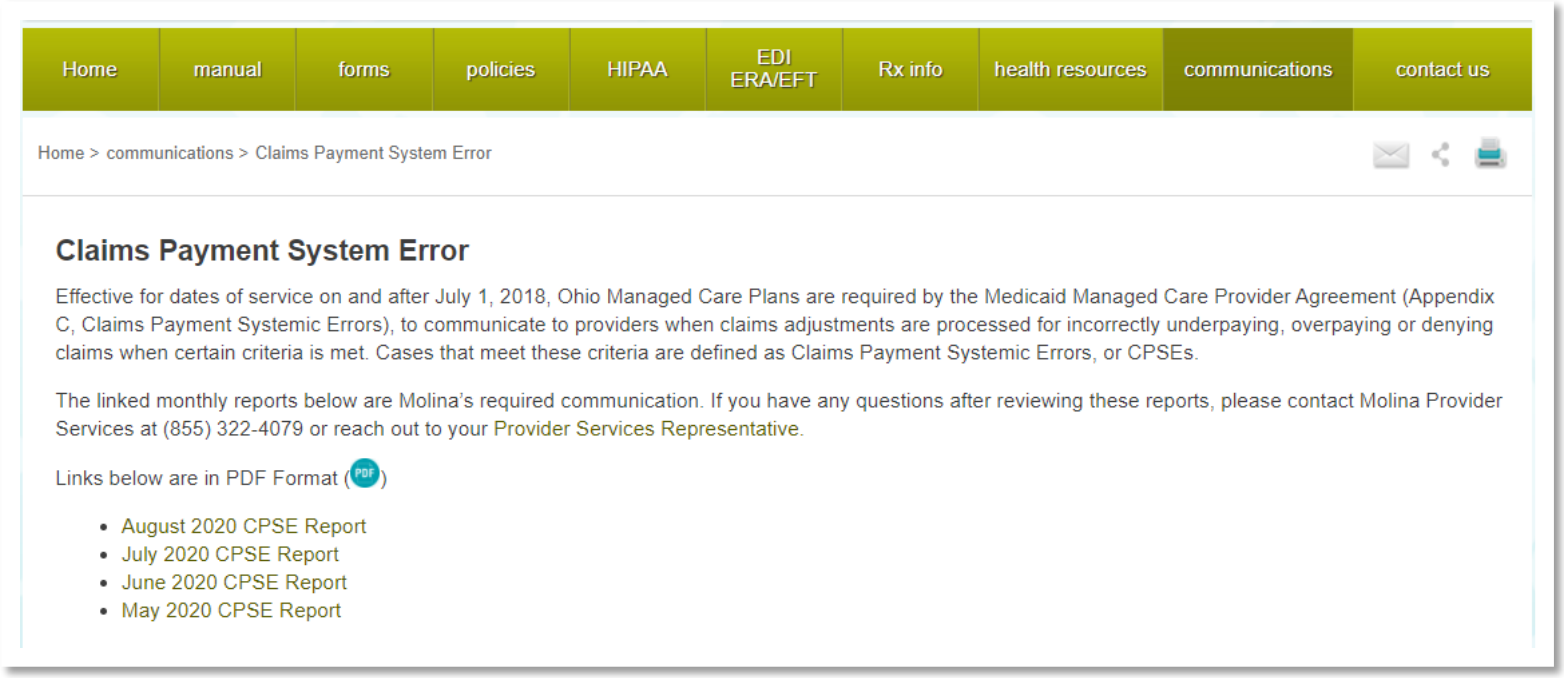
Thank you OAMES members for the care you provide to our members. We understand how challenging rendering services has become during the COVID-19 pandemic.

View the “COVID-19 (Coronavirus)” page on our provider website at MolinaHealthcare.com under the “Communications” tab for COVID-19 information.



Claims Payment System Error Report

Molina added a Claims Payment System Errors (CPSE) page to the Molina Website, under the “Communications” tab. Molina posts our CPSE reports each month for provider communication.



CPSEs are not posted on the Provider Portal

Note: The Ohio Department of Medicaid (ODM) is notified when five or more providers are impacted by the same CPSE.

Mechanism for Contacting Non-Par HME Providers when Patient is Transferred from ODM, Continued

As noted in the Molina Provider Manual:

Transition of Care – Medicaid

Members Age 21 and Older: Honor Medicaid Fee-for-Service (FFS) prior authorizations (PAs) for no less than 90 days from the enrollment effective date. After the 90 days has expired, the Managed Care Plan (MCP) can conduct a Medical Necessity review pursuant to OAC Rule 5160-26-03.1.

Members Under Age 21: Unless noted in the Molina Provider Manual, the MCP must honor Medicaid FFS PA for no less than 90 days from the enrollment effective date. After the 90 days has expired, the MCP can conduct a Medical Necessity review pursuant to OAC Rule 5160-26-03.1. The MCP must honor the Medicaid FFS PA for 90 days or the duration of the PA, whichever is longer, for the following items:

- Enteral Feeding Supply Kit
- Hearing Aids
- Synthesized Speech Generating Devices
- Parenteral Nutritional Supply Kits

Published Guidance for Durable Medical Equipment, Prosthesis, Orthotics and Supplies (DMEPOS) Benefit

Access to Claims Processing and Coverage Criteria Guidance:

- Molina follows the DME guidelines as referenced in the ODM Supply List and the Orthotic and Prosthetic List.
- It is imperative that appropriate billing is used to identify the services provided and to process claims accurately.
- For additional guidance on the DMEPOS benefit, view the "Durable Medical Equipment" section in Appendix A of the Molina Provider Manual on the Molina Provider Website at www.MolinaHealthcare.com/OhioProviders, under the "Manual" tab.

Timelines for Claims Adjudication Processes Specific to DMEPOS:

Claim processing will be completed for contracted providers in accordance with the Ohio Medicaid Program Prompt Pay Requirements.

Medically Unlikely Edit (MUE)

Molina uses Cotiviti and Claims Edits System (CES) for editing.

You can read more on MUE standards in the Molina provider manual, available at www.MolinaHealthcare.com/OhioProviders, under the “Manual” tab.

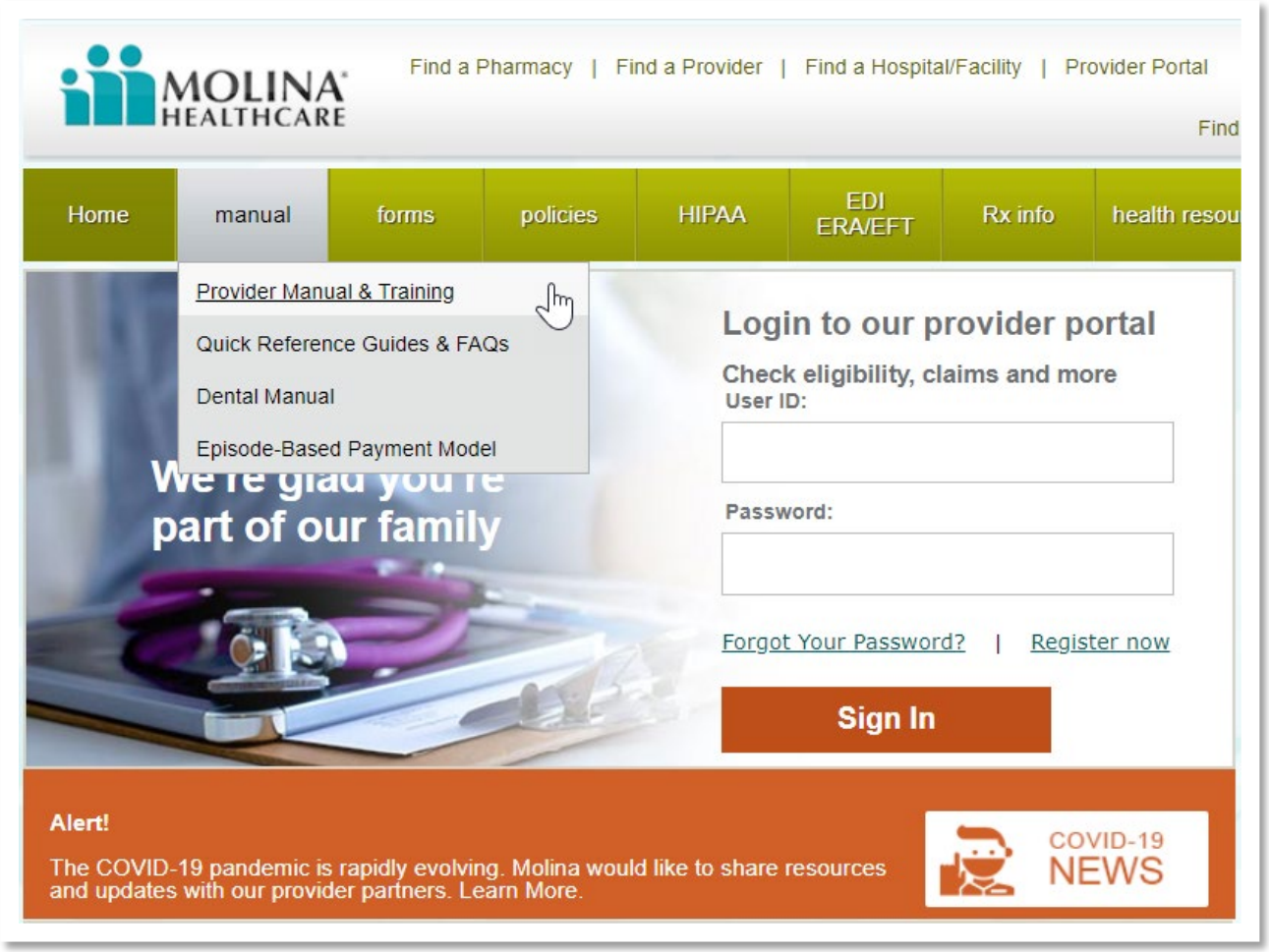
Third Party Claims Audits

Molina utilizes a Claims adjudication system that encompasses edits and audits that follow the state and federal requirements as well as administers payment rules based on generally accepted principles of correct coding.

You can read more on Third Party Claims Audit in the Molina provider manual, available at www.MolinaHealthcare.com/OhioProviders, under the “Manual” tab.

Healthcare Common Procedure Coding System (HCPCS)

Molina does not have a published list of HCPCS codes that require a date span. Information regarding DME can be found in the Molina Provider Manual, available at www.MolinaHealthcare.com/OhioProviders, under the “Manual” tab and “Provider Manual & Training.”



Advanced Notification on Planned Recoupments of Paid Claims

In the event Molina finds an overpayment on a claim or must recoup money, a letter requesting the refund will be mailed to the provider.

- This letter will contain all claims in question and the reason for the recoupment.
- The provider has 60 days to dispute/appeal or refund Molina by check or accounts receivable will be established, and the amount of the overpayment will be deducted from the provider's next check(s).
- All recovery activity will appear on the provider's remittance advice.
- All recovery activity will appear on the provider's remittance advice.
- Use the Return of Overpayment Form to submit unsolicited refunds or check returns. The Return of Overpayment Form can be found at www.MolinaHealthcare.com/OhioProviders under the "Forms" tab, in "Provider Forms," under "Claims." .

Modifiers and Status Indicators

Medicaid Requirements

Reimbursement varies based on the Status Indicator. Utilize the table to the right to determine which indicator to bill. Please note an indicator is different than a modifier.

Type	Status Indicator
Purchase Only	PP
Rental Only	RO
Rental To Purchase	RP

Modifier	Definition
NU	New equipment purchase, including complete replacement of an owned item
RR	Equipment rental
RP	Repair and replacement parts for patient owned equipment
UE	Used

Medicare Modifier Requirements

A modifier based on whether the authorization shows it to be a new purchase or a rental.

Correct pricing is driven by these modifiers. Utilize the table to the left to view valid modifiers.

Reminder: Information regarding the appropriate modifiers can be found in the Molina Provider Manual.

Modifiers and Status Indicators

Capped DME Rental Modifiers

To identify the rental months billed use these modifiers:

Modifier	Definition
KH	First rental month
KI	Second and third rental months
KJ	Fourth through fifteenth rental months

Reminder: Information regarding the appropriate modifiers can be found in the Molina Provider Manual, located under the "Manual" tab at www.MolinaHealthcare.com/OhioProviders.

Questions and Answers

Q: Does your plan consider paid claims recouped in error as “overpayments” and does the timeline (TFL) for a provider to challenge the recoupment was taken in error?

A: Molina would need claim examples to review and provide a resolution regarding overpayments being recouped in error. A provider has 120 days from the remittance date to dispute a claim.

Q: If each plan has clearly defined TFL for all healthcare providers, will the plan limit recoupment on place of service or eligibility conflicts to the same period of time as the TFL threshold?

A: Molina can audit a claim randomly. An audit can occur at any time. Molina utilizes a claims adjudication system that encompasses edits and audits that follow the state and federal requirements, as well as administers payment rules based on generally accepted principles of correct coding.

Questions and Answers, Continued

Q: Across all Managed Care Plans, providers report receiving denials at the prior authorization and claims levels when attempting to provide Custom Wheelchairs on a dual plan in a facility setting. These should be approved on the Medicaid portion of the plan without requiring submission to Medicare first for a denial.

Then we appeal, get paid and a third-party auditor will deny and recoup leading to another appeal to get our money back. What can providers do to resolve this issue?

A: Molina can discuss this concern with individual providers who have claims examples to provide. We cannot provide a global response without a review of a claim.

Questions and Answers, Continued

Q: Recoupments for reasons like “Place of service conflict, patient was inpatient on date of DME delivery” often occur when provider has contacted the family, the specific hospital or Long-Term Care Facility (LTCF) and cannot verify an inpatient stay at time of delivery.

Recoupments have been more than 1,100 days from date of service. Is there a mechanism or process the DME supplier uses with the Plan to obtain specific information about which facility stay is causing the place of service conflict?

A: Below is a link to our “DME Coordination for Dual Eligible Members.” This link will speak to place of service (POS), when to use each specific POS, and the denials received when you bill the incorrect POS. Please review for a complete understanding of POS conflicts prior to billing Molina for the services provided to our members.

https://www.molinahealthcare.com/providers/oh/duals/~/media/Molina/PublicWebsite/PDF/providers/oh/Duals/oh-duals-dme-grid.pdf

Questions and Answers, Continued

Q: ODM claims allow HME providers to bill monthly claims based on calendar months verses specific date spans. Will Molina align with the ODM policy?

A: Molina follows ODM guidance when processing DME claims.

Q: Are DME providers included in the Provider Information Attestation Federal requirement? If yes, how will Molina contact providers every 90 days?

A: Molina reached out to OAMES for further clarification/citation related to this requirement in order to provide an accurate response.

Contacting Provider Services

Provider Services is available 8 a.m. to 6 p.m. Monday through Friday for MyCare Ohio; from 8 a.m. to 5 p.m. for all other Lines of Business.

Call (855) 322-4079 for the services below.

- Care Management
- Claims/ Claims Inquiry
- Pharmacy
- Prior Authorization
- Provider Portal Help Desk
- Eligibility
- Utilization Management
- Behavioral Health
- Contracting/ Credentialing

For general DME/Long-Term Services and Supports (LTSS) questions or training contact: OHMyCareLTSS@MolinaHealthcare.com

Questions?

Phone:

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Email:

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Thank You!