MOLINA HEALTHCARE

PROVIDER NEWSLETTER

A newsletter for Molina Healthcare Provider Networks

Third Quarter 2019

In this Issue

Submitting Electronic Data Interchange (EDI) Claims

Look at all the benefits to using EDI:

- Electronic Claims Submission ensure HIPAA compliance
- Electronic Claims Submission helps to reduce operational costs associated with paper claims (printing, postage, etc.)
- Electronic Claims Submission increases accuracy of data and efficient information delivery
- Electronic Claims Submission reduces claims delays since errors can be corrected and resubmitted electronically!
- Electronic Claims Submission eliminates mailing time and claims reach Molina faster!

EDI Claims Submission

The easiest way to submit EDI claims to Molina Healthcare is through a Clearinghouse. You may submit the EDI through your own Clearinghouse or use Molina's contracted Clearinghouse. If you do not have a Clearinghouse, Molina offers additional electronic claims submissions options. Log onto Molina's Provider Services Web Portal https://provider.molinahealthcare.com for additional information about the claims submission options, available to you.

FAQ'S

- Can I submit COB claims electronically?
  - Yes, Molina and our connected Clearinghouses fully support electronic COB.
- Do I need to submit a certain volume of claims to send EDI?
  - No, any number of claims via EDI saves both time and money.
- Which Clearinghouses are currently available to submit EDI claims to Molina?

- Molina Healthcare uses Change Healthcare as our channel partner for EDI claims. You may use the Clearinghouse of your choice. Change Healthcare partners with hundreds of other Clearinghouses.

- What claims transactions are currently accepted for EDI transmission?
  - 837P (Professional claims), 837I (Institutional claims).
- What if I still have questions?
  - More information is available at www.molinahealthcare.com under the EDI tab. You may also call or email us using the contact information below.

Submitting Electronic Claims
1-866-409-2935
EDI.Claims@MolinaHealthcare.com
Molina Healthcare of _____ Payer ID: __ __ __ __ __

Electronic Fund Transfer (EFT)

Molina has partnered with our payment vendor, ProviderNet, for Electronic Funds Transfer and Electronic Remittance Advice. Access to the ProviderNet portal is FREE to our participating providers and we encourage you to register after receiving your first check from Molina.

New ProviderNet User Registration:

1. Go to https://providernet.adminisource.com
2. Click "Register"
3. Accept the Terms
4. Verify your information
   a. Select Molina Healthcare from Payers list
   b. Enter your primary NPI
   c. Enter your primary Tax ID
   d. Enter recent claim and/or check number associated with this Tax ID and Molina Healthcare
5. Enter your User Account Information
   a. Use your email address as user name
   b. Strong passwords are enforced (8 or more characters consisting of letters/numbers)
6. Verify: contact information; bank account information; payment address
   a. Note: Any changes to payment address may interrupt the EFT process.
   b. Add any additional payment addresses, accounts, and Tax IDs once you have logged in.

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

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 ftp and/or associated Clearinghouse

If a provider has questions regarding the actual registration process, they can contact ProviderNet at: (877) 389-1160 or email: wco.provider.registration@changehealthcare.com.

Note: Providers please ensure you are registered for EFT for all participating Lines of Business.

Are You Culturally Competent?

Cultural and linguistic competency is the ability to provide respectful and responsive care to members with diverse values, beliefs and behaviors, including tailoring health care delivery to meet members' social, cultural and linguistic needs. The National CLAS (Culturally and Linguistically Appropriate Services) Standards, developed by the Health and Human Services Office of Minority Health, aim to

improve health care quality and advance health equity by establishing a collective set of mandates and guidelines that inform, guide and facilitate culturally and linguistically appropriate services.

Communicating Across Cultures

Clear communication is the foundation of culturally and linguistically competent care.

Guiding the conversation

- Initial greetings can set the tone for an interaction. If the patient's preference is not clear, ask how they would like to be addressed (i.e. Mr. Jones, Michael, and Ms. Gonzalez).
- Ask open-ended questions whenever possible.
- Some individuals can tell you more about themselves through story telling than by answering direct questions.
- Inquire about preferred language and preferred method of communication (i.e. written, spoken, graphics, sign language, assistive listening devices, etc.).
- Consider treatment plans with respect to the patient's culture-based beliefs about health.
- Ask about any complimentary or alternative medicine possibly used by the patient.

Assisting patients whose preferred language is not English

- Speak slowly and try not to raise your voice
- Use simple words and avoid jargon
- Do not use acronyms, idioms and avoid technical language if possible. (i.e. shot vs. injection)
- Please articulate words
- Give information in small chunks and short sentences
- Repeat important information and have the patient repeat information back to you
- If you are using an interpreter:
    - hold a brief introductory discussion with the interpreter
    - Inform the interpreter of any specific patient needs
    - Reassure the patient about confidentiality
    - Allow enough time for the interpreted sessions
    - Avoid interrupting during interpretation
    - Speak in the first person
    - Talk to the patient directly, rather than addressing the interpreter

Please remember that it is never permissible to ask a minor, family member or friend to interpret.

Molina's language access services

Molina strives to ensure good communication with members by providing language access services. Section 1557 of the ACA requires that all limited English proficient (LEP) beneficiaries' language access needs be met for all medical appointments. To refuse an LEP beneficiary access to language services is a violation of that individual's civil rights. The ACA also prohibits providers from

requesting a beneficiary to provide his or her own interpreter or rely on a staff member who is not qualified to communicate directly with the LEP individual. Language access services ensure mutual understanding of illness and treatment, increase patient satisfaction and improve the quality of health care for Limited English proficiency patients.

Molina provides the following services to members at no cost:

- 24-hour access to interpreter services for members with limited English proficiency (LEP).
- Sign Language Interpreter Services
- Relay Service (711)
- Member materials written simply in plain language and at required reading levels.
- Written material translated into languages other than English
- Written material in other formats (i.e. large print, audio, accessible electronic formats, Braille)
- 24 Hour Nurse Advice Line
- Bilingual/Bicultural Staff

Please call Molina's ***Member and Provider Contact Center*** to arrange for language access services:

- For Medi-Cal members call (888) 665-4621 Mon-Fri, 7am-7pm
- For Marketplace members call (888) 858-2150 Mon-Fri, 8am-6pm
- For Medicare members call (800) 665-0898 Mon-Fri, 8am-8pm
- For Cal MediConnect (Duals) members call (855) 665-4627 Mon-Fri, 8am-8pm

For after-hours and weekends, please call Molina's Nurse Advice Line to arrange for this service:

- English (888) 275-8750
- Spanish (866) 648-3537

Sources:

U.S. Department of Health & Human Services: Office of Minority Health. Health Research & Educational Trust, 2013.
Industry Collaboration Effort, Better Communication, Better Care: Provider Tools to Care for Diverse Populations.
Industry Collaboration Effort, Cultural and Linguistic Services, 2017.

Maternal Mental Health Program

Effective July 1, 2019, AB 2193 Maternal Mental Health requires a licensed health care practitioner who provides prenatal or postpartum care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions. The American College of Obstetricians and Gynecologists (ACOG) reports that depression is very common in women, especially in women of reproductive age. Perinatal depression affects as many as one in seven women. ACOG recommends that OBs and other obstetric care providers screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool.

Molina requires the use of a validated tool to assess the member's mental health, either in the prenatal or postpartum period, or both. Two examples are the Patient Health Questionnaire (PHQ-9) form https://www.uspreventiveservicestaskforce.org/Home/GetFileByID/218, and the Edinburgh Postnatal Depression Scale (EPDS) form https://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf,

both of which are widely utilized. Providers may document mental health screening using the following claim codes:

- **G8431 (positive**) with modifier HD for Medi-Cal members, and
- **G8510 (negative)** with modifier HD for Medi-Cal members.

Pregnant/postpartum members with positive screening results may be treated by the Provider within the Provider's scope of practice. When the condition is beyond the Provider's scope of practice, the Provider must refer the member to a mental health provider within the Molina network. Molina providers may screen further for referrals into the County system of care if clinically indicated.

Medi-Cal and MMP Members: OBs, PCPs, and mental health providers in Molina's network must refer pregnant/postpartum members with **significant impairment** resulting from a covered mental health diagnosis to the County Mental Health Program. Per DHCS APL 17-018, *"Significant impairment in an important area of life functioning or a reasonable probability of significant deterioration in an important area of life functioning would qualify for referral to the County Mental Health Plan."* Additionally, when the member has a significant impairment and the diagnosis is uncertain, Molina providers must ensure the member is referred to the County MHP for further assessment.

- Los Angeles ACCESS line: 800-854-7771
- San Bernardino Access and Referral Line: 1-800-743-8256
- Riverside Community Access, Referral, Evaluation, and Support (CARES) Line: 1-800-706-7500
- Imperial County Access Unit: (442) 265-1597 or (442) 265-1596
- Sacramento Mental Health Access Team: (916) 875-1055 or toll free (888) 881-4881
- San Diego Access and Crisis Line: 1-888-724-7240

Molina High Risk OB Program: In addition to treatment by the provider or referral to a mental health provider, practitioners may also refer to Molina's High Risk OB Program for case management support and follow-up. The program utilizes a collaborative team approach that includes risk screening and identification by Molina nurses, clinical case management for members with positive screenings, and member education to promote optimal pregnancy outcomes for Molina pregnant members. Please call the number below to refer members:

- **Molina High Risk OB Program: (866) 891-2320**

Pharmacy Update - Lorbrena

Lorbrena (lorlatinib) is a third-generation tyrosine kinase ALK inhibitor made by Pfizer. It was given accelerated approval by the FDA for the treatment of anaplastic lymphoma kinase (ALK)-positive, metastatic, non-small cell lung cancer (NSCLC) in patients whose disease has progressed on specified therapies (other ALK inhibitors) on November 2, 2018.

Lung cancer is the second most common cancer in the U.S. and the leading cause of cancer deaths. NSCLC is the most common type of lung cancer. Adjuvant therapies typically involve regimens with cisplatin or carboplatin. In metastatic cases that are ALK gene rearrangement positive, alectinib, crizotinib, ceritinib, or brigatinib may be used.

In a non-randomized, multi-center study of a subgroup of 215 patients with ALK positive NSCLC previously treated with one or more ALK inhibitors, the overall response rate with lorlatinib treatment

was 48%. The estimated median response rate was 12.5 months. Common adverse reactions were edema, peripheral neuropathy, cognitive effects, dyspnea, fatigue, weight gain, arthralgia, mood effects, and diarrhea, occurring in greater than or equal to 20% of patients.

Lorlatinib is contraindicated in patients taking strong CYP3A4 inducers. The recommended dose is 100 mg orally daily until disease progression or unacceptable toxicity.

References:
1. Food and Drug Administration. FDA approves lorlatinib for second- or third-line treatment of ALK-positive metastatic NSCLC. https://www.fda.gov/Drugs/InformationOnDrugs/ApprovedDrugs/ucm625027.htm. Accessed February 11, 2019.
2. NCCN Guidelines Version 4.2018: Non-Small Cell Lung Cancer
3. Lorlatinib. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Hudson, OH. Available at: http://online.lexi.com Accessed February 11 2019.

Model of Care

2019 Molina Health Model of Care Provider Training

The Centers for Medicare & Medicaid Services (CMS) requires all contracted medical Providers and staff receive basic training about the Special Needs Plans (SNPs) Model of Care. The SNPs Model of Care is the plan for delivering coordinated care and care management to special needs Members. SNPs are responsible for conducting their own MOC training, which means you may be asked to complete multiple trainings by different health plans. CMS requires us to show evidence of the availability of MOC training materials communicated to Providers.

The completion date for this year's training is October 31, 2019. Please complete the Model of Care training and submit the signed attestation via fax, which can be found online at https://www.molinahealthcare.com/providers/common/medicare/Pages/medicare.aspx

If you have any additional questions, please contact your local Molina Healthcare Provider Services Representative at (855) 322-4075.

Is Your Authorization Request Urgent?

CMS defines expedited/urgent authorization requests as - "applying the standard time for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function"

When submitting urgent/expedited prior authorization requests, keep the following items in mind to ensure the request is processed without delay:

- Urgent/Expedited service request designation should only be used if the treatment 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 will be handled as routine/ non-urgent.

- Priority is based on turn-around time and then order of receipt.
- Molina Healthcare's regulation turn-around time is up to 72 hours for urgent and up to 14 days for standard, however this could vary based on line of business.
- For a smoother, faster process please remember to include all the supporting clinical/documents.

DirectAssure

We are now collaborating with DirectAssure to help maintain a more accurate and timely provider directory. Working in concert with CAQH ProView®, which is accessed by 1.4 million providers to self-report and regularly attest to their professional and practice information, DirectAssure enables providers to update their directory information once and share it with all participating health plans they authorized to receive that data.

We encourage all providers to sign up for CAQH ProView® in order to utilize DirectAssure as a tool to easily update and distribute provider directory data to Molina Healthcare. DirectAssure reduces the burden on healthcare providers and health plans alike, eliminating redundant outreach and increasing directory accuracy.

How DirectAssure Works:

- DirectAssure emails reminders, on at least a quarterly basis, to select providers on behalf of participating health plans to review their directory information.
- Providers log in to CAQH ProView®, review a specific dataset in a Provider Directory Snapshot, make any necessary updates and then confirm that the directory information can be published.
- The confirmation is time stamped, and a snapshot of information is taken for audit purposes.
- This directory data includes provider location, contact information, specialty, medical group, institutional affiliation and whether they are accepting new patients.

To register, please visit https://www.caqh.org/. For more information about DirectAssure, visit https://www.caqh.org/solutions/directassure.
If you have any questions, please contact your Provider Services Representative.

Provider Portal Corner

We have enhanced the Provider Portal to include access to the PDF images of the Explain of Payment (EOP) documents that come with your Molina claims payments. EOPs can be accessed for claims that have a paid/denied status. Navigation to the EOP is done through the Claims Inquiry module of the Portal. Search for the desired claim, and from the Claims Details page, select the "EOP" button. This will open the PDF of the EOP.

Claim Details

General Information

Member Name: LNAME, FNAME
Claim Source: EDI
Claim Header Status: Denied
Rendering Provider Name: TESTER, PROVIDER
Rendering Provider NPI: 1234567890
Check Paid Date: 05/07/2019
Service Date To: 2/22/2019
Claim Number: 19126123456
Claim Status Effective: 2/22/2019
Billed Amount($): 166.29
Check Number: EFT1234567
Service Date From: 2/22/2019
Patient Control Number: 112233A44556
Amount Paid($): 0.00

Claim Line Items

Claim Line	Service From Date	Service To Date	Rev Code	Service Code	Modifiers	Units	Billed Amt	Deductible	Co-Ins	Paid Amt	Co-Pay	Line Status Effective	Status	Adj Grp Cd	Adj Rsn Cd	Rmk Cd
1	02/22/2019	02/22/2019		99214		1	166.29	0.00	0.00	0.00	0.00	2/22/2019	Denied	OA	18	

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DESCRIPTION OF HIPAA ADJUSTMENT & REMARK

ADJ GRP CODE	DESCRIPTION
OA	Other Adjustment

ADJ RSN CODE	DESCRIPTION
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)

Save As Template | Appeal Claim | Void Claim | Correct Claim | View Diagnosis Code | Print Claim Summary | EOP | Back