Molina Healthcare of Ohio Nursing Facility and Assisted Living Provider Guide

MOLINA® HEALTHCARE

Your Extended Family.

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Topics in this guide were chosen based on most frequently asked questions and the most common challenges nursing facilities have when delivering care to Molina Healthcare members. For additional questions, please email our Molina Healthcare provider representatives at OHProviderServicesNF@MolinaHealthcare.com or call (855) 322-4079.

Molina Healthcare of Ohio's nursing facilities network is an essential part of delivering quality care to our members. We value our partnership and appreciate the care and compassion providers pass on to Molina Healthcare members enrolled in Medicaid, Medicare or Molina Dual Options MyCare Ohio Medicare-Medicaid or Molina Dual Options MyCare Ohio Medicaid Only Plans. As partners in care, one of our highest priorities is to help providers serve our members.

Molina Healthcare wants to make sure we remain extremely flexible and open to meeting provider needs and the needs of our members. We are committed to open communication and

welcome feedback on how the process is working. We look forward to supporting all provider efforts towards delivering high-quality care.

For more information regarding Molina Healthcare, please visit our website at www.MolinaHealthcare.com/OhioProviders and select the appropriate line of business (LOB) from the dropdown menu.

General Information

Molina Healthcare is here to help get services authorized, including admission pre-certification, continued length of stay authorizations or notifications of a change in the member's level of care (LOC). Molina Healthcare's Health Care Services (HCS) department assigns care review clinicians (licensed nurses) and care managers (licensed nurses and social workers) to each facility, giving a consistent point of contact.

Medicaid-certified nursing facilities provide health-related care and services (above the level of room and board) not available in the community as described below:

- **Short term stay** – skilled care provided in a nursing facility, usually for a period of time less than 100 days that is typically covered by Medicare or may be covered by Medicaid based on the member's eligibility and need.

- **Long term stay** – care provided in a nursing facility, covered by Medicaid, for those members who require the level of care provided by a nursing facility and no longer can live independently in their own home or with family or friends.

Patient Liability (PL) is the monthly amount that a member receiving nursing facility services may be required to contribute to the cost of his/her care depending on the individual state income regulations. This amount is calculated using the member's income and subtracting reasonable allowances for personal needs and other living expenses. Nursing facilities are required to collect the entire PL due each month. Payments made to nursing facilities are reduced by the PL amount due for the months billed.

To become a Molina Healthcare contracted nursing facility, please complete the "Non-Participating Provider Contract Request Form" available under the "Forms" tab at www.MolinaHealthcare.com/OhioProviders.

Definitions

Medicare Definitions:

- **Custodial Care –** non-skilled, non-medical (personal) care:
  - Help with daily living activities such as bathing, dressing, eating, getting in or out of bed or chair, moving around, and using the bathroom
  - It may also include the kind of health-related care that most people do by themselves
  - The care can reasonably and safely be provided by non-licensed caregivers

Medicare will not cover custodial care if it is the only care an individual needs

- **Skilled Care –** individual requires:
  - Daily skilled care that can *only* be provided by or under the supervision of skilled or licensed medical personnel
  - Skilled rehabilitation is considered daily for the purposes of this definition if the individual is offered and utilizes the rehab services at least five days per week
  - Individual must also meet additional eligibility requirements for Medicare to pay for the skilled nursing facility stay (please reference the Medicare website at www.Medicare.gov for more information)

Medicaid Definitions:

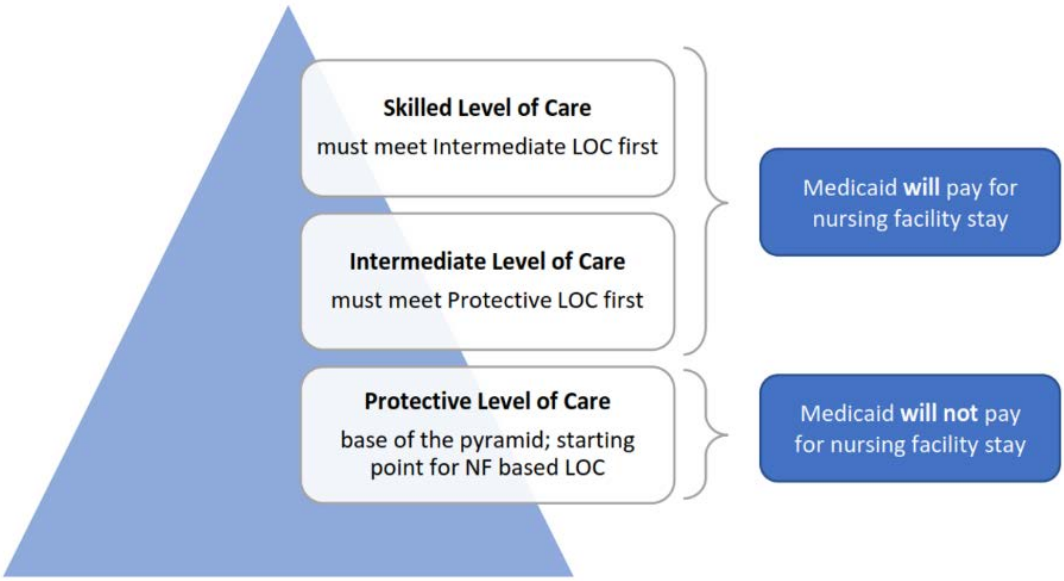
- **Skilled Nursing Services –** means specific tasks that must, in accordance with Chapter 4723 of the Revised Code, be provided by a licensed practical nurse (LPN) at the direction of a registered nurse or by a registered nurse directly

- **Skilled Rehabilitation Services –** means specific tasks that must, in accordance with Title 47 of the Revised Code, be provided directly by a licensed or other appropriately certified technical or professional health care personnel

- **Protective Level of Care (LOC) –** described in OAC 5160-3-06; Medicaid will *not* pay for a nursing facility stay if the individual *only* meets a protective level of care

- **Intermediate LOC –** described in OAC 5160-3-08; Medicaid will pay for a nursing facility stay if the individual meets an intermediate level of care

- **Skilled LOC –** described in OAC 5160-3-08; Medicaid will pay for a nursing facility stay if the individual meets a skilled level of care



Verifying Eligibility

In addition to checking the member ID card, it is important to verify eligibility. To determine if a patient is eligible to receive Molina Healthcare benefits:

- Check your current eligibility roster
- Log on to www.MolinaHealthcare.com/OhioProviders and log in to the Provider Portal
- Call Provider Services at:
    - Medicaid: (855) 322-4079, Monday through Friday from 8 a.m. to 5 p.m.
    - Molina Dual Options (full benefits): (855) 322-4079, Monday through Friday from 8 a.m. to 6 p.m.
    - Molina MyCare Ohio Medicaid (opt-out): (855) 322-4079, Monday through Friday from 8 a.m. to 6 p.m.
- Medicaid providers can call the ODM Interactive Voice Response (IVR) System 24 hours a day, seven days a week to confirm eligibility for MCP or Fee-for-Service Medicaid consumers
    - Providers must have a PIN number to access this information

It is the responsibility of the providers to check eligibility. If the patient is not currently eligible or assigned to Molina Healthcare at the time of service, the claim will be denied. To minimize claims payment issues, it is strongly recommended that eligibility be verified at every encounter prior to rendering the service.

Utilization Management/Authorizations

1. What is the process for nursing facility admission pre-certifications?

The majority of pre-certifications will take place through the discharge planning process, when a member in need of post-acute nursing facility care is identified. Molina Healthcare's Care Review Clinicians will be in direct contact with the acute inpatient facilities, assisting with the discharge process and ensuring that medically necessary nursing facility admissions occur in a timely manner. These requests for nursing facility admissions are reviewed and a determination is rendered within 48 hours. In the event that a member is an emergent admit (i.e. direct admit from home or emergency room due to imminent safety risk) to a nursing facility after normal business hours, Molina Healthcare will accept notification from the nursing facility of the admission on the next business day. Please provide clinical information to support the admission.

2. What documents are required to submit for authorization and what is the process to submit them?

Required Documents:

- Medical Doctor (MD) Orders
- History/Physical

- Pre-admission Screening and Resident Review (PASARR) documents: a federal requirement for placement in nursing homes with Long Term Care (LTC)
  PASARR is completed by:
  - Agency on Aging (AAA)
  - Ohio Department of Mental Health and Drug Addiction
  - Ohio Department of Developmental Disabilities
- Minimum Data Set (MDS): contains items that reflect the acuity level of the resident, including diagnosis, treatments and an evaluation of the resident's functional status
  - Used as a data collection tool to classify Medicare residents into Resource Utilization Groups (RUG)

Submission Process:

Molina Healthcare will use whatever method works best for each facility:

- Provider Portal: providers are encouraged to use the Molina Healthcare Provider Portal for Prior Authorization (PA) Submission at http://Provider.MolinaHealthcare.com
- Prior Authorization Request Form: the PA Request Form is available on our website at www.MolinaHealthcare.com/OhioProviders under the "Forms" tab and can be faxed to the appropriate LOB fax number listed at the top of the form

3. Is the authorization documented electronically and immediately available to the nursing facility?

Yes. Nursing facilities have access to this information in the Molina Healthcare Provider Portal at http://Provider.MolinaHealthcare.com.

4. Is the authorization electronically tied to the claims processing system?

Yes. Molina Healthcare automatically ties the authorization to the claim submitted.

5. What is the turnaround time for the authorization?

Patient / Care Type	Documentation Required
Routine (non-expedited) Pre-service determinations	Within 10 calendar days of receipt of the request
Expedited/Urgent determination	Within 48 hours from receipt of information reasonably necessary to make a decision

6. Does the health plan need supporting documents from the nursing facility in order to pay a claim?

Generally, no. We will need documentation for coordination of benefits (COB).

7. What training is available on authorization procedures?

Molina Healthcare staff is available to provide orientations and trainings to all contracted nursing facilities. Contact our Provider Services department at OHProviderServicesNF@MolinaHealthcare.com.

8. Who is responsible for calling in the request for the pre-certification?

- **The Nursing Facility** – is responsible for contacting Molina Healthcare to get pre-authorization
- **The hospital's discharge planner** – is responsible for working with Molina Healthcare to find a facility that will accept the member
    - The discharge planner needs to instruct the facility to call Molina Healthcare for the precertification

9. What steps are needed if a Molina Healthcare member needs additional care beyond the date of original authorization?

To request an extension for a Molina Healthcare authorization, fax the request to the Molina Healthcare Prior Authorization Department fax number available on the top of the Prior Authorization Form for the appropriate LOB.

Documents required:

- Member Demographics
- PA Number
- Facility and clinical documentation to support the need for an extension

Molina Healthcare will require ongoing contact with either the nursing facility or designated review company for clinical updates, depending on the member's LOC as follows:

- **Skilled Nursing LOC**:
  Notification every seven days; or sooner, if clinical presentation changes
    - MCG Skilled Nursing guidelines are utilized to determine medical necessity for skilled nursing stays
- **Custodial Nursing LOC for LTC members for whom the nursing facility is their home**:
  Notification every six months; or sooner, if the member moves to a skilled level of care
    - Molina Healthcare will reach out to the provider facility initially to clarify the original date of admission and to confirm the LOC
    - **Note**: When any therapies (physical, occupational or speech) being billed under the member's Part B benefit are implemented, the facility will need to contact Molina Healthcare for authorization
- **Hospice LOC**:
  Notification every six months; no medical necessity review is required with a physician's order

10. How are Waiver Services determined?

All assisted living waiver services must be authorized on a waiver services plan (WSP) per the waiver services coordinator or Molina Healthcare care manager.

11. How does Molina Healthcare reimburse for Bed Hold Days?

- Medicare does not reimburse for leaves of absence from the facility
- Bed hold days will be reimbursed under the member's Medicaid benefit for up to 30 days per calendar year
- The nursing facility does not need to notify Molina Healthcare if bed hold days are being utilized for our LTC members, but is responsible for tracking and adhering to the 30-day benefit limit

12. What happens when the Medicare 100 day Skilled Nursing benefit is exhausted?

In the case of a Molina MyCare Ohio Medicaid-Only member:

- The primary Medicare carrier will issue the Integrated Denial Notice (IDN) to the member

A Molina Dual Options MyCare Ohio member (who has chosen Molina Healthcare to administer both their Medicare and Medicaid benefits):

- Molina Healthcare will issue the IDN to the member

In either event, Molina Healthcare will continue to review for skilled need under the member's Medicaid benefit.

13. How are changes in Level of Care (LOC) handled?

- **Urgent acute hospital admissions from the nursing facility**:
  - The acute facility will be responsible for contacting Molina Healthcare the next business day to provide notification of the emergent admission
  - The nursing facility will be responsible for tracking any required bed hold days under the member's Medicaid benefit
- **Planned (non-emergent) acute hospital admissions**:
  - The acute facility and/or member's treating physician are responsible for getting precertification for the planned acute admission
  - The nursing facility will be responsible for tracking any required bed hold days under the member's Medicaid benefit
- **Transfer to Hospice**:
  - Medicaid covers the facility room and board charges
  - Molina Healthcare requires notification when the Molina Dual Options MyCare Ohio Medicare-Medicaid plan member has elected to use their Medicare hospice benefit
  - Pre-certification with Molina Healthcare is not required

14. How will Care Coordination (Case Management) interventions be handled?

- Care Management oversight of the member includes assistance with care coordination and development of a plan of care with perceived barriers, goals and interventions, geared to promote the member's optimal level of support and wellness

- Collaboration with the care management team in assessing LOC needs, which may require a face-to-face assessment, is coordinated with the care management team by emailing NFMCOPmailbox@MolinaHealthcare.com and requesting a new LOC assessment
- A dedicated Molina Healthcare care manager will work with a provider to coordinate Interdisciplinary Care Team conferences and provide other support systems as needed
- Contact between a facility and the dedicated care manager will be scheduled in advance by contacting the designated point person, the social worker or MDS coordinator

Claims Management

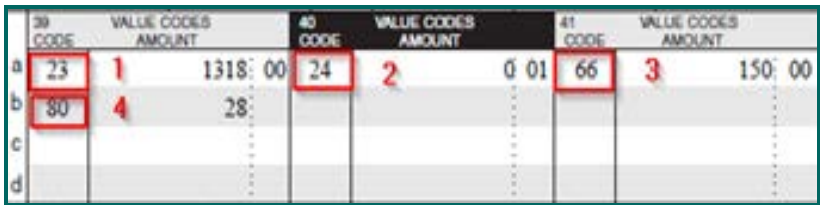
In order to ensure timely payment for skilled nursing and assisted living waiver providers and reduce the manual burden associated with unnecessary claim rejections and/or denials, the following billing guidance should be utilized by all nursing facilities. This information was obtained from current Medicare and Medicaid billing practices found in the National Uniform Billing Committee (NUBC) UB04 Uniform Billing Manual and Transaction and Code Set Standards of Centers for Medicare and Medicaid Services (CMS).

Claims Submission

1. A facility may submit claims as frequently as desired. Molina Healthcare issues payment checks on:
   a. Monday – OH Medicare Advantage Prescription Drug Plan (MAPD), Medicaid, Marketplace, MyCare Ohio and Secondary
   b. Tuesday – OH MAPD, MyCare Ohio and Secondary
   c. Wednesday – OH MAPD
   d. Thursday – OH MAPD, Medicaid, Marketplace, MyCare Ohio and Secondary
   e. Friday – OH MAPD
   f. The last day of the month - Medicaid
2. When submitting a nursing facility claim, a provider must:
   a. Bill on an 837 Electronic Data Interchange (EDI) claim.
      i. Molina Healthcare payer ID 20149
   b. Submit through the Molina Healthcare Provider Portal
3. Billed services for any claim should not overlap two consecutive calendar months
4. Medicare claims must be submitted within 365 days after date of service (DOS)
5. Molina Healthcare of Ohio claims must be submitted within 120 days after DOS

Claims Value Codes

1. Use value code 23 in field 39a and enter share of cost (SOC) in the amount field
2. Use value code 24 in field 40a and enter accommodation code in the amount field
3. Use value code 31 for lump sum
4. Use value code 66 in field 41a and enter non-covered services (NCS) in the amount field
5. Use value code 80 in field 39b and enter number of days of care in the amount field
6. Use value code 81 for non-covered days



The following grids identify bill types/revenue codes to use:

MEDICAID

Medicaid Bill Types*	
Medicaid inpatient claims	0213
Medicaid adjustment claims	0217
Medicaid cancel claims	0218

Medicaid LTC Revenue Codes	
Full covered day	0101
Full day: short-term stay for waiver consumer	0160
Leave day: therapeutic	0183
Leave day: hospital	0185
Flat fee: full covered day	0220
Flat fee: full day short-term stay for waiver consumer	0169
Flat fee: leave day	0189
Flat fee: full covered day (reduced rate)	0229
Flat fee: short-term stay for waiver consumer (reduced rate)	0769
Flat fee: leave day (reduced rate)	0180

*Other bill types as noted below under Medicare Part A can be used, but these are the most frequent. Religious Nonmedical Healthcare Institutions should use bill type 041X.

Medicaid Skilled Nursing Facility Part A Bill Types	
Admit through discharge	0211
Interim, first claim	0212
Interim, continuing claim	0213
Final claim	0214
Replacement prior claim	0217
Void/cancel prior claim	0218

Medicaid Skilled Nursing Facility Part A Revenue Codes	
All-inclusive room and board	0101
Therapeutic leave (bed-hold days) excludes PA1/PA2 acuity level -)- payment based on occupancy rate	0183
Hospitalization leave (bed-hold days) excludes PA1/PA2 acuity level -)- payment based on occupancy rate	0185
Respite care: short-term stay for waiver consumer	0160
PA1/PA2 acuity level per diem	0220
PA1/PA2 - acuity level respite care per diem: short-term stay for waiver consumer	0169
PA1/PA2 acuity level per diem: leave day - payment based on occupancy rate	0189
Other respiratory services, per diem for member in NF Ventilator Program **Note**: In order to qualify as an NF Ventilator Program provider and receive enhanced payment for providing ventilator services, a NF shall meet all of the following criteria: • Have an approved ODM 10198, "Addendum To ODM Provider Agreement For Ventilator Services In Nursing Facilities" • Provide services to individuals who are ventilator dependent and have Medicaid as their primary payer • Designate a discrete unit within the NF for the use of individuals in the NF ventilator program • Have ventilators connected to emergency outlets, which are connected to an on-site backup generator in an amount sufficient to meet the needs of the ventilator dependent individuals • Provide all of the following services: o A minimum of five hours per week of a licensed respiratory therapist or the services of a registered nurse who has worked for a minimum of one year with ventilator dependent individuals o Initial assessments for physical therapy, occupational therapy, and speech therapy within forty-eight hours of receiving the order for a ventilator dependent individual o Up to two hours of therapies per day, six days per week o Access to laboratory services that are available twenty-four hours per day, seven days per week with a turnaround time of four hours o Administer pain medications to a ventilator dependent individual within two hours from the receipt of the physician order	0419
Note: • Long Term Care facility room and board claims do not require procedure (CPT/HCPCS) codes • For nursing facility room and board claims use Box 54 to report patient liability amount and lump sum amounts per month	

MEDICARE

Skilled Nursing Facility (SNF) Part A Bill Types Extended care services furnished to inpatients of a Medicare certified SNF. Patients must require daily skilled care on an inpatient basis.	
Nonpayment/zero claim	210
Admit through discharge	211
Interim, first claim	212
Interim, continuing claim	213
Final claim	214
Late charges only claim	215
Replacement prior claim	217
Void/cancel prior claim	218

Medicare SNF Inpatient Part A Revenue Codes	
SNF Prospective Payment System (PPS)	0022 and HIPPS RUG Code

Medicare Swing Bed Inpatient Part A Billing Types	
Nonpayment/zero claim	0180
Admit thru discharge	0181
Interim, first claim	0182
Interim, continuing claim	0183
Final claim	0184
Late changes only claim	0185
Replacement prior claim	0187
Void/cancel prior claim	0188

Medicare Swing Bed Inpatient Part A Revenue Codes	
SNF Prospective Payment System (PPS)	0022 and HIPPS RUG Code

Medicare Part A Condition Codes
Field 18-28 required when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. This list of codes, including instructions, can be found in NUBC UB04 Uniform Billing Manual.

Medicare Part A Occurrence Codes & Occurrence Span Codes
Field 35-36 Occurrence Codes and Occurrence Span Codes are typically used when there is a coordination of benefits. This list of codes and instructions can be found in NUBC UB04 Uniform Billing Manual.

Medicare Part B Inpatient:
Part B inpatient stays include services furnished to inpatients whose benefit days are exhausted, or who are not entitled to have payment made for services under Part A.

Medicare Skilled Nursing Facility Inpatient Part B Only Bill Type	
Admit thru discharge	0221
Interim, first claim	0222
Interim, continuing claim	0223
Final claim	0224
Late changes only claim	0225
Replacement prior claim	0227
Void/cancel prior claim	0228

Medicare Skilled Nursing Facility Inpatient Part B Only Revenue Codes	
Covered Ancillary Codes	0271, 0272, 0274, 030X-032X, 0333, 034X-035X, 038X-039X, 040X, 042X-044X, 046X, 048X, 0540, 061X, 0636, 073X-075X, 0770, 0771, 0923, 0942

Medicare Part B Outpatient:
Part B outpatient services are rendered to a patient who no longer meets the Medicare skilled level of care (SLOC). It is also used when patients are moved to a non-Medicare certified area or distinct part unit of the facility because they no longer require a SLOC. Beneficiaries residing in such portions of the facility are considered outpatients of the SNF for Medicare purposes.

Medicare SNF Outpatient Part B Bill Type	
Admit thru discharge	0231
Interim, first claim	0232
Interim, continuing claim	0233
Final claim	0234
Late changes only claim	0235
Replacement prior claim	0237
Void/cancel prior claim	0238

Medicare SNF Outpatient Part B Revenue Codes	
Covered Ancillary Codes	0271, 0272, 0274, 030X-032X, 0333, 034X-035X, 038X-039X, 040X, 042X-044X, 046X, 048X, 0540, 061X, 0636, 073X-075X, 0770, 0771, 0923, 0942

Outpatient Therapy Caps – Medicare claims are no longer subject to the therapy caps (one for occupational therapy services and another for physical therapy and speech-language pathology combined) in accordance with the Bipartisan Budget Act (BBA) of 2018. For Molina Healthcare Medicare Plans, claims for therapy services above a certain amount of incurred expenses, which is the same amount as the previous therapy caps ($2,010 in 2018), continue to require prior authorization.

Assisted Living

All assisted living services must be billed on a CMS 1500 claim form. Molina Healthcare requires the correct Healthcare Common Procedure Coding System (HCPCS) and modifier combination billed on every claim. The following chart may be referenced as a guide for billing assisted living waiver claims. Bed hold days are not billable for assisted living waiver members.

HCPCs Code	Medicaid LOC	Required Modifier	Unit Increment
T2031	Tier 1	U1	1 day
	Tier 2	U2	1 day
	Tier 3	U3	1 day
T2038	Community Transition Services	U4	1 Completed Job Order

Hospice

Participating hospice providers will not bill directly for the room and board (Revenue Code 065X and HCPCS Code T2046).

Participating nursing facilities will be responsible for billing room and board and:

- Must bill hospice room and board on a Uniform Billing (UB) form using Revenue Code 065X along with HCPCS Code T2046, and Molina Healthcare will reimburse 95 percent of the facility per diem rate in accordance with OAC 5160-56-06 Hospice services: reimbursement.
- Must only bill for days that the member is in the nursing facility or Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF-MR) overnight
- Can bill for members who have elected the hospice benefit under Medicare, but are Medicaid eligible and reside in a Medicaid-reimbursed nursing facility or ICF-MR for the room and board

HCPCs Code	Service Type
T2046	Hospice Room and Board

Covered and Non-Covered Days

Days reported as covered (value code 80) should only be days Molina Healthcare is responsible for paying during the Statement Covers Period (From and Through dates). Days Molina Healthcare is not responsible for (i.e., person is ineligible) during this period should be reported

as non-covered days (value code 81). Report these numbers separately at the claim line detail level or the claim will deny.

- The number of covered days (value code 80) must match the number of units and charges reported for the covered room and board days
- The number of non-covered days (value code 81) must match number of units and charges being reported on a separate line at the detail level for the non-covered room and board days
  - Report charges related to the non-covered days under Total Charges and Non-Covered Charges
  - Discharge date should not be considered a non-covered day
- The sum of the covered days and non-covered days room and board units at the claim line detail level must equal the sum of value codes 80 and 81 days and the Statement Covers Period (From and Through dates) or the claim will deny

Timely Claim Filing

The provider shall promptly submit claims to Molina Healthcare for covered services rendered to members. All claims shall be submitted in a form acceptable to and approved by Molina Healthcare, and shall include any and all medical records pertaining to the claim if requested by Molina Healthcare or otherwise required by Molina Healthcare's policies and procedures. Claims must be submitted by provider to Molina Healthcare within 120 days after the following have occurred: discharge for inpatient services or the date of service for outpatient services. If Molina Healthcare is not the primary payer under coordination of benefits or third party liability, provider must submit claims to Molina Healthcare within 90-days after the date of the final determination by the primary payer. Except as otherwise provided by law or provided by government program requirements, any claims that are not submitted to Molina Healthcare within these timelines shall not be eligible for payment and the provider hereby waives any right to payment therefore.

Original Claims: Claims for covered services rendered to Molina Healthcare members must be received by Molina Healthcare no later than the filing limitation stated in the provider contract or within 120 days from the date of service(s). Claims submitted after the filing limit will be denied.

Corrected Claim: Claims received with a correction of a previously adjudicated claim must be received by Molina Healthcare no later than 365 days from the date of the remit of the claim number that is being corrected. Effective April 1, 2018, corrected claims must be submitted with the Molina Healthcare claim ID number from the original claim being corrected, and with the appropriate corrected claim indicator based on claim form type.

Coordination of Benefits: Claims received with explanation of benefits (EOB) from the primary carrier attached must be submitted to Molina Healthcare within the greater of the above time frame or within 90 days of the date listed on the EOB from the other carrier.
The provider may request a review for claims denied for untimely filing by submitting justification for the delay as outlined in the Claims Reconsideration section of Provider Manual on our website at www.MolinaHealthcare.com/OhioProviders under the "Manual" tab. Acceptable proof of timely filing must include documentation with the following:

- The date the claim was submitted
- The insurance company billed (address/payer ID) was Molina Healthcare

- The claim record for the specific patient account(s) in question

Claim Reconsideration Request (Disputes): See the Claim Reconsideration section in the Provider Manual on our website for information and timeframes regarding review of a claim payment and/or denial.

Refer to the Non-Contracted Provider Billing Guidelines for timely filing and claim reconsideration requirements specific to non-participating providers.

Corrected Claims

Corrected Claims are considered new claims for processing purposes. Corrected claims must be submitted electronically with the appropriate fields on the 837I or 837P completed. Molina Healthcare'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 a Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P.

Claims submitted without the correct coding will be returned to the provider for resubmission.

Corrected claim submissions are not adjustments and should be directed through the original submission process marked as a corrected claim.

Common Billing Errors that Cause Claims to Deny

- Missing, incomplete or invalid:
  - number of covered days during the billing period
  - number of non-covered days during the billing period
  - replacement claim information
  - bill type
  - discharge status
  - codes:
    - Healthcare Common Procedure Coding System (HCPCS) codes
    - Current Procedural Terminology (CPT) codes
    - Occurrence codes

For additional information refer to the most recently published Uniform Billing Expert (UBE) Billing Guide, and the Ohio Department of Medicaid (ODM) Hospital Billing Guide available at http://Medicaid.Ohio.gov/ under "Resources" then "Publications" select "ODM Guidance" then "Provider Billing Instructions" and under "ODM Hospital Billing Guidelines" select "For Dates of Discharge and Dates of Service On or After 8/1/2017."

Patient Liability

Patient Liability (PL) is the amount of money a consumer is required to pay out-of-pocket each month to a specific, assigned provider. This amount is determined by the consumer's county caseworker at the County Department of Job and Family Services (CDJFS).

PL is:

- Defined in Ohio Administrative Code (OAC) 5160: 1-3-24
- A post-eligibility treatment of income
- Variable based on the income of the member
- Has the potential to change on a monthly basis
- Cannot be calculated and imposed on a member by providers

PL applies to claims for the following services:

- Nursing facility claims billed on a UB with Bill Type:
  - 0210-0218
  - 0180-0188
  - 0221-0228
  - 0231-0238
- Hospice claims billed with code T2046 (room and board)
- Assisted Living T2031
- Certain Home and Community-Based Waiver services
- Personal care aid T1019
- Home care attendant – nursing and personal care S5125
- Nursing services T1002 & T1003
- Adult day services S5100, S5101, S5102

Note: All PL will apply to the nursing facility claim if the member is a nursing facility resident. The authorization must state to whom provider of record PL will be applied.

Additional information for PL is available in our Patient Liability Guide located on our website at www.MolinaHealthcare.com/OhioProviders under the "Manual" tab on the MyCare Ohio line of business.

Part B Therapy

All professional and outpatient claims with CPT/HCP CS/Rev drug code details must have the corresponding valid NDC code submitted with the CPT/HCPCS drug code or the claims will be denied.

Drugs acquired through the 340B drug pricing program must be billed with an SE modifier so they can be properly excluded from federal drug rebates. For more information, see the Provider Manual on our website at www.MolinaHealthcare.com/OhioProvider under the "Manual" tab.

Per the final Medicare 2018 Outpatient Prospective Payment System rule, modifiers JG and TB will be used to signify use of a 340B drug. For claims that crossover directly to ODM from

Medicare, ODM will request rebates for eligible drugs, as appropriate. If a provider submits a claim for a dually eligible individual directly to ODM, ODM will expect proper reporting of the SE modifier in accordance with ODM guidelines. This is important for providers who serve both Medicaid and MyCare Ohio members.

More information is available at http://www.healthlawpolicymatters.com by searching "Medicare 340B Reimbursement."

Care Management Overview

Care Managers work to ensure Molina Healthcare members are at the appropriate LOC and have timely access to needed covered benefits, carved out services and community resources. The state requires that care managers assess for the members' willingness and ability to return to community living, as well as help facilitate that transition, if needed. Molina Healthcare often partners with other community based organizations to assist in facilitating the members needs while transitioning to community. The care manager will work with the provider and these agencies to ensure a smooth process for the member.

The care manager is to partner with nursing facility care coordinators and other nursing facility staff to ensure member's care is holistically integrated and coordinated to find ways to avoid preventable hospital admissions, readmissions, and emergency room visits. The care manager participates in person- and family-centered service planning with the nursing facility staff, primary care provider, vendors, and other state and community agencies to coordinate managed and non-managed services, including non-Medicaid community resources.

The care manager conducts face-to-face visits with the nursing facility member annually or for reassessment as determined by the member's condition, situation, and LOC.

1. **How can a nursing facility find out which care manager is assigned to a member and/or nursing facility?**

   To determine a Molina Healthcare member's assigned care manager, contact us with the member's full name and date of birth via any of the following methods:
   Phone: (855) 322-4079
   Email: NFMCOPmailbox@MolinaHealthcare.com

2. **When should a nursing facility contact the care manager/service coordinator?**

   The care manager or service coordinator assigned to a facility will maintain regular contact with the facility designee. Should a provider encounter a barrier to care for any of our members, we encourage providers to contact the care manager or service coordinator. This list is not mutually exclusive. The following are examples of when the care manager/service coordinator should be notified:

- There is a change in the member's physical or mental health and/or has a change in the LOC needed
- The member goes to the emergency room or is admitted to the hospital
- The member relocates or passes away
- Bed holds
- When a member elects hospice
- When there are questions about a member's care plan
- When a member expresses a desire to return to the community

Note: For an authorization, we recommend submitting a PA via:

- Provider Portal: providers are encouraged to use the Molina Healthcare Provider Portal for PA Submission at http://Provider.MolinaHealthcare.com
- Prior Authorization Request Form: the PA Request Form is available on our website at www.MolinaHealthcare.com/OhioProviders under the "Forms" tab and can be faxed to the appropriate LOB listed at the top of the form.

3. What are the care managers/service coordinators responsibility?

- Coordinating services when a member transitions into a nursing facility
- Partnering with the member, family, nursing facility care coordinator, nursing facility staff and others in the development of a service plan, including:
    - services provided through the nursing facility
    - add-on services
    - acute medical services
    - behavioral health service
    - primary or specialty care
- The approval of additional services outside of the nursing facility daily unit rate is based on medical necessity and benefit structure
- Participating in nursing facility care planning meetings telephonically or in person, provided the member does not object
- Comprehensively reviewing the member's service plan, including the nursing facility plan of care, annually or when there is a significant change in condition
- Evaluating members living in nursing facilities at least quarterly
    - Visit to include, at minimum:
        - a review of the member's service plan
        - a review of the member's clinical record
        - when possible, a person-centered discussion with the member about the services and supports the member is receiving
        - any unmet needs or gaps in the member's service plan
        - any other aspect of the member's life or situation that may need to be addressed.

Additionally, during the visit the care manager or service coordinator will interact with nursing facility staff as needed to assure the member's needs and concerns are being addressed

- Assisting with the collection of applied income when a nursing facility has documented unsuccessful efforts, per the state-mandated nursing facility requirements. The care manager or service coordinator will reach out to the responsible party who controls the

funds and explain the importance of paying the applied income, as it could put the member at risk of being discharged or being relocated for non-payment to the nursing facility

4. **Will Molina Healthcare have on-site care managers who conduct the medical review of nursing facility residents?**

MyCare Ohio members are assigned a Molina Healthcare care manager who will conduct a comprehensive assessment on the member at least once a year.

Individualized Care Plan

An Individualized Care Plan (ICP) is a summary of the medical needs and social service options identified in the assessment process and is an outline of the plan developed by the member (and/or authorized representative) and the care manager to meet the member's needs.

New Molina Healthcare members:
- The initial assessment must be completed within 75 calendar days after enrollment
- The ICP must be completed within 15 calendar days after the initial assessment

Current Molina Healthcare members:
- The ICP must be completed with 14 calendar days of any identified health changes or reassessment

ICP must include:
- Current and unique physical, psychosocial and medical needs and history of the member, as well as member's functional level, behavioral health needs, language, culture, and support systems
- Identifiable and measurable short- and long-term treatment and service goals and interventions to address the member's needs and preferences and to facilitate monitoring of the member's progress and evolving service needs
- Expected outcomes with completion timeframes
- Opportunities for input from the member, his or her designee, and the Multidisciplinary Team (MDT) during the development, implementation, and ongoing assessment of ICP
- A risk assessment that identifies and evaluates risks associated with the member's care
    - Factors considered include (but are not limited to):
        - health status
        - ability to comprehend risk
        - caregivers qualifications and risks associated with burn-out or the ability to no longer perform duties
        - reasonable accommodations
        - behavioral or other compliance risks

Multidisciplinary Team (MDT) or Interdisciplinary Care Team (ICT) requirements and responsibilities:

- The MDT must be comprised, first and foremost, of the member and/or his or her designee
- ICP is developed by the member and his or her MDT that addresses clinical and non-clinical needs identified in the comprehensive assessment and includes goals, interventions and expected outcomes
- The member shall be encouraged to identify individuals that he or she would like to participate on the MDT, including but not limited to family members, responsible parties, or other informal caregivers such as neighbors or friends
- The care manager/service coordinator serves as the lead MDT member
- The MDT must also consist of the following staff:
    - the member's PCP or designee
    - the member's behavioral health clinician (if applicable)
    - the member's Long Term Support Services (LTSS) provider
    - If necessary include the following:
        - transition coordinator (if applicable)
        - Home and Community Based Services (HCBS) provider
        - waiver care manager
        - a pharmacist (if necessary)
        - hospital discharge planners
        - nursing facility representatives (if applicable)
        - registered nurse
        - specialist
        - any other professional and support disciplines, including social workers, community health workers, and qualified peers, who may be able to provide subject matter expertise and input, advocates, state agency or other care managers
- Must provide the member with a copy of his or her ICP

Pharmacy

Medicaid:
Phone: (855) 322-4079
Fax: (800) 961-5160

Medicare:
Phone: (855) 322-4079
Fax: (866) 290-1309

MyCare Ohio:
Phone: (855) 322-4079
Fax: (866) 290-1309

Pharmacy provider responsibilities:

- Adhere to the Formulary/Preferred Drug List (PDL)
- Coordinate with the prescribing physician
- Ensure members receive all medications for which they are eligible

- Coordination of benefits when a member also receives Medicare Part D services and other benefits

Nurse Advice Line (NAL)

Molina Healthcare has a toll free multi-lingual nurse advice telephone line available to members and providers on a 24-hour basis, seven days per week. Staff on this advice line take calls from members and perform triage services to help determine the appropriate setting from which they should obtain necessary care. In all instances, the staff on the advice line coordinates all care with the member's primary care physician.

The Nurse Advice Line is accessed through a toll free telephone number, as well as through information in the Member Handbook and other written material.

The Nurse Advice Line phone numbers are:

- Medicaid, Medicare and Marketplace
  - English: (888) 275-8750 TTY: 711
  - Spanish: (866) 648-3537 TTY: 711
- MyCare Ohio
  - English and Spanish: (855) 895-9986 TTY: 711

Provider Complaints, Appeals and Grievances

Molina Healthcare maintains an organized and thorough grievance and appeals process to ensure timely, fair, unbiased and appropriate resolutions. Molina Healthcare members or their authorized representatives have the right to voice a grievance or submit an appeal through a formal process.

Molina Healthcare ensures that members have access to the appeal process by providing assistance throughout the whole procedure in a culturally and linguistically appropriate manner; including oral, written and language assistance. Grievance information is also included in the Member Handbook.

Members may authorize a designated representative to act on their behalf. Members must provide their written consent for someone to act on their behalf during the appeal or grievance process. This representative may be a friend, a family member, health care provider or an attorney.

Members may file a grievance by calling Molina Healthcare's Member Services Department:

- **Medicaid**: (800) 642-4168 (TTY/Ohio Relay (800) 750-0750 or 711), Monday through Friday from 7 a.m. to 7 p.m.
- **Molina Dual Options MyCare Ohio (full benefits)**: (855) 665-4623 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.

- **Molina Dual Options MyCare Ohio Medicaid (opt-out)**: (855) 687-7862 (TTY 711). Monday through Friday from 8 a.m. to 8 p.m.
- **Medicare**: (866) 472-4584 (TTY711) – 8 a.m. to 8 p.m., Monday through Sunday

Members may submit a grievance in writing to:

- **Medicaid and MyCare Ohio:**
  Molina Healthcare of Ohio, Inc.
  Attn: Appeals and Grievances Department
  P.O. Box 349020
  Columbus, Ohio 43234-9020

- **Medicare:**
  Molina Healthcare of Ohio, Inc.
  Attn: Appeals and Grievances Department
  P.O. Box 22816
  Long Beach, CA 90801-9977

Molina Healthcare will investigate, resolve and notify the member or representative of the findings.

Receipt of Grievance:

- Two working days of receipt of a grievance related to accessing medically-necessary covered services in the Medicaid or Molina Dual Options MyCare Ohio LOB
- 30 calendar days of receipt for grievances that are not claims related in Medicaid, Medicare or Molina Dual Options MyCare Ohio LOB

Grievance regarding bills or claims:

- 60 calendar days for grievances regarding bills or claims in the Medicaid LOB
- 30 calendar days for grievances regarding bills or claims in the Molina Dual Options MyCare Ohio LOB

Receipt of Standard Appeal requests:

- 15 calendar days of receipt for Medicaid and Molina Dual Options MyCare Ohio Appeals
- 30 calendar days of receipt for Marketplace Appeals

Receipt of Expedited Appeal requests:

- Determine within 24 hours if the appeal request meets expedited criteria
- If the appeal request meets expedited criteria, resolve within 72 hours of receipt

In general, members must exhaust the internal appeals process prior to filing an external appeal (e.g. State Fair Hearing or Independent External Review). If the appeal resolution isn't fully resolved in the member's favor, Molina Healthcare will notify the member of their right to external appeal rights.

Ombudsman

LTC Ombudsmen safeguard consumers of care services, advocating for quality care, investigating complaints and giving them a voice. About half of these regional programs are part of the Area Agency on Aging, while the other half are housed within community service and advocacy agencies.

Ombudsmen field complaints about LTC services, voice clients' needs and concerns to nursing homes, home health agencies and other providers of LTC. While they do not "police" nursing homes and home health agencies, they work with the LTC provider, member, member's families or other representatives to resolve problems and concerns a member may have about the quality of services he or she receives.

Ombudsmen will:

- link a member with the services or agencies he or she need to live a more productive, fulfilling life
- advise a member on selecting a LTC in Ohio
- inform a member about the rights of consumers
- provide information and assistance with benefits and insurance.

Contacting Molina Healthcare

Provider Services:

Email Address: OHProviderServicesNF@MolinaHealthcare.com

Customer Services Phone Number: (855) 322-4079

Fax: (866) 713-1894

Care Services:

Utilization Management
Phone: (855) 322-4079

MyCare Ohio Case Management
Email: NFMCOPmailbox@MolinaHealthcare.com

Phone: (855) 665-4623
Ask for the Duals Case Management queue line Monday through Friday 8 a.m. to 5 p.m.

Nurse Advice Line: (888) 275-8750
Ask to be transferred to the on-call duals care manager.
All day Saturday and Sunday, holidays, and Monday through Friday 5 p.m. to 8 a.m.

Behavioral Health:
Phone: (855) 322-4079

Fax: (866) 553-9262

Additional Information

Care	Molina Dual Options MyCare Ohio members (Molina Healthcare administers both Medicare and Medicaid benefit)	Molina MyCare Ohio Medicaid member (Molina Healthcare administers only the Medicaid benefit)	Molina Healthcare Contact Person
Bed Hold Days	*30 days / calendar year under Medicaid benefit- No notification required	*30 days / calendar year under Medicaid benefit- No notification required	N/A
Hospice	*Notification only. Medical necessity review is not required with physician's order *Medicaid covers facility room and board	*Notification only. Medical necessity review is not required with physician's order *Medicaid covers facility room and board	Assigned Utilization Management (UM) Care Review Clinician
Readmit from acute hospital to skilled bed	*Authorization required *3-day stay requirement waived	*Notification only. No authorization required until 100 skilled Medicare days have been exhausted	Assigned UM Care Review Clinician
Care	**Molina Dual Options MyCare Ohio members** (Molina Healthcare administers both Medicare and Medicaid benefit)	**Molina MyCare Ohio Medicaid member** (Molina Healthcare administers only the Medicaid benefit)	**Molina Healthcare Contact Person**
Readmit from acute hospital to custodial bed	*Notification only *Authorizations entered for 6-month periods	*Notification only *Authorizations entered for 6-month periods	Assigned Case Management (CM) Care Manager
New admission skilled	*Authorization required. 3-day stay requirement waived *Authorizations entered for 7-day periods	*Notification only. No authorization required until 100 skilled Medicare days have been exhausted *Authorizations entered for 7-day periods	Assigned UM Care Review Clinician
New admission custodial	*Notification only with authorizations entered for 6-month periods	*Notification only with authorizations entered for 6-month periods	Assigned CM Care Manager

Currently admitted Level of Care (LOC) moves from skilled to custodial	*Notification only if member is previously established long-term placement *If long-term placement has not been established, must notify assigned Care Manager to complete LOC assessment. Custodial authorization will be entered for 1 month, pending LOC assessment	*Notification only if member is previously established long-term placement. *If long-term placement has not been established, email NFMCOPmailbox@MolinaHealthcare.com to complete LOC assessment. Custodial authorization will be entered for 1 month, pending LOC assessment	Assigned UM Care Review Clinician / Assigned CM Care Manager (for non- LTC members)
Currently admitted LOC moves from custodial to skilled	*Authorization required *Authorizations entered for 7-day periods	*Notification only. No authorization required until 100 skilled Medicare days have been exhausted	Assigned UM Care Review Clinician
Ancillary / Support Services not included in Per Diem (non-hospice)	*Subject to Molina Healthcare's Prior Authorization List (on Molina Healthcare website) *Service provider will obtain authorization directly with Molina Healthcare	* Medicare Primary Services: No prior authorization with Molina Healthcare required. Molina Healthcare will adjudicate claims for secondary Medicaid benefit utilizing Medicare EOB. *Medicaid Primary Services: Refer to Molina Healthcare Prior Authorization grid.	Assigned UM Care Review Clinician for full duals member
Care	**Molina Dual Options MyCare Ohio members** (Molina Healthcare administers both Medicare and Medicaid benefit)	**Molina MyCare Ohio Medicaid member** (Molina Healthcare administers only the Medicaid benefit)	**Molina Healthcare Contact Person**
Therapies (Physical, Occupational and/or Speech) billed under Medicare Part B, at custodial LOC	* Authorization required * Outpatient Therapy Caps – Medicare claims are no longer subject to the therapy caps (one for occupational therapy services and another for physical therapy and speech-language pathology combined) in accordance with the Bipartisan Budget Act (BBA) of 2018. For Molina Medicare Plans, claims for therapy services above a certain amount of incurred expenses, which is the same amount as the previous therapy caps ($2,010 in 2018) continue to require prior authorization.	* No prior authorization with Molina Healthcare required. Molina Healthcare will adjudicate claims for secondary Medicaid benefit utilizing Medicare EOB if Part B therapy cap has been reached.	Assigned UM Care Review Clinician
New Enrollee in MyCare Ohio while in facility	*Contact Molina Healthcare for prior authorization / notification	*Contact Molina Healthcare for prior authorization / notification	Assigned UM Care Review Clinician

(either skilled or custodial)			

Additional Resources

- PA Code List
- Provider Manual
- Provider Web Portal Quick Reference Guide
- Claims Submission Training