Making the Connection

Provider Newsletter • 3rd Quarter 2017

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Claims System Transition

Effective July 1, 2017 Molina Healthcare (Molina) completed the transition to a new claims processing system. We are very excited by the efficiencies the system will bring to our providers. We have enclosed a sample Explanation of Payment (EOP) from our new system as it is different than the one you have received previously. This new version is the EOP that you will receive for all claims with dates of service on or after July 1, 2017.

Molina will continue to process claims with dates of service prior to July 1, via our old claims payment system through December 31, 2017. Please submit your claims in accordance with the timely filing requirements outlined in your contract, as claims cannot be processed after we have closed down the system.

Molina Healthcare recommends all Contracted Providers to register for Electronic Funds Transfer (EFT) within thirty days of receipt of their first check from the new system. You will be able to sign up to receive Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) via our vendor ProviderNet. You may register to receive both electronic payment and remittance advice via their website: https://providernet.adminisource.com after receiving your first paper check from Molina on our new claims system (claims processed with DOS after July 1, 2017).

All providers who register for EFT are automatically enrolled to receive Electronic Remittance Advice (ERA). The benefits of EFT/ERA:

- Faster payment (as little as 3 days from the day the claim was electronically submitted)
- Search historical ERAs by claim number, member name, etc.
- View, print, download and save PDF ERAs for easy reference
- Providers can have files routed to their ftp and /or their associated clearinghouse

To register for EFT/ERAs with Change Healthcare go to: https://providernet.adminisource.com/Start.aspx

Step-by-step registration instructions are available on Molina's website www.molinahealthcare.com under the "EDI, ERA/EFT" tab.

Paper Claims

Molina requires all providers to bill electronically, however if you are unable to submit a claim electronically the address for paper submission is:

Molina Healthcare of New York, Inc.
Po Box 22615
Long Beach, CA 90801

Molina Claims Filing

Effective September 15, 2017 all Claims must be submitted by the Provider to Molina within ninety (90) calendar days after the discharge for inpatient services or the Date of Service for outpatient services, **unless otherwise noted in your Contract**.

All disputed claims must be submitted within 90 days from the date of the explanation of payment (EOP). The adjustment request form can be found on the **Molina website at** www.molinahealthcare.com**. Select New York in the dropdown at the top of the page.**

All written Claim disputes must be submitted on the form found on Provider website. *The form must be filled out completely in order to be processed*. Forms may be submitted via fax, or mail. Claims Disputes/Reconsideration requests may be sent to the following address:

Molina Healthcare of New York, Inc.
Attention: PIRR Department
5232 Witz Dr.
North Syracuse, NY 13212
Or via Fax: (315) 234-9812

MolinaHealthcare.com

Claim Submissions

All claims billed to Molina must include the appropriate value for 'Patient Relationship to Insured'. If this code is not populated, your claim will be rejected.

Below is a summary definition with acceptable values, however, please reference the appropriate New York State Billing and Companion Guides for specific details and guidance.

Patient's Relationship to Insured
Code indicating the relationship of the patient to the identified insured.

Location:

Paper - UB-04 Form Locator 59
Electronic – Loop ID 2000B or 2000C (if not subscriber)

Values for this Data Element

Code	Title	Code	Title
01	Spouse	39	Organ Donor
18	Self	40	Cadaver Donor
19	Child	53	Life Partner
20	Employee	G8	Other Relationship
21	Unknown		

All claims billed to Molina on a HCFA 1500 or an 837P electronic file must include a physical address in Box 33 on the HCFA 1500 or Loop 2010AA, N3 Segment in an 837P electronic file. If this address is not a physical address, the claim will be rejected.

Coming Soon: Provider Portal

We anticipate the release of the Provider Portal towards the end of August and we will be contacting you as soon as it is available to provide you with one-on-one registration instructions. The Provider Portal (https://provider.molinahealthcare.com) is available free of charge and makes it easier for you to take care of business on your schedule as its available 24/7. You and your staff will be able to check member eligibility, download a member roster, submit claims with attachments, request authorization, including notice of inpatient admissions, and much more!

Reminder New Prior Authorization Form and Guidelines, Effective July 1.

Molina Healthcare implemented a new Prior Authorization Guide, as well as an updated Prior Authorization Request Form, and Codification Matrix. These documents are located on our website at MolinaHealthcare.com under Provider Resources>Prior Authorization. Please be sure you are using the new form to submit your Prior Authorization/Service Request to Molina.

MolinaHealthcare.com

Access and Availability

All Molina Healthcare of New York (Molina) Health Plan Network Providers are expected to adhere to the New York State Department of Health "Appointment Availability Guidelines" in our Provider Manual. Molina expects that all providers provide 24/7 access to care for our members. Providers are expected to have a live voice answering phone calls during business hours and a live answering service for those needing access to care afterhours. To ensure compliance with the rules and regulations Molina Healthcare of New York Health conducts access and availability survey calls to randomly selected providers throughout the year.

NEW YORK STATE DEPARTMENT OF HEALTH ACCESS & AVAILABILITY SURVEY RESULTS

IPRO on behalf of NYS DOH conducted the annual A&A Survey to assess the compliance with appointment timeframe requirements per the NYS Medicaid Managed Care Contract, Section 15. The study evaluated the availability of routine and non-urgent "sick" office hour appointments as well as the availability of after-hours access. All calls were made to participating primary care physicians, including Internal Medicine/ Family Practice, Pediatric and OB/GYN providers. Total Routine, Total Non-Urgent and Total After Hours resulting in 75% or less are considered a failure by NYS DOH.

REGION	CALL TYPE	PROVIDER TYPE	PROVIDERS SURVEYED	TOTAL APPOINTMENTS	REGION COMPLIANCE RATE
3	Routine	Internist/Family Practitioner	263	150	57.0%
		Pediatrician	113	73	64.6%
		OB/GYN	88	45	51.1%
		Total Routine	464	268	57.8%
	Non-Urgent "Sick"	Internist/Family Practitioner	179	84	46.9%
		Pediatrician	74	37	50.0%
		OB/GYN	58	23	39.7%
		Total Routine	311	144	46.3%
	After Hours Access	Internist/Family Practitioner	89	50	56.2%
		Pediatrician	36	26	72.2%
		OB/GYN	32	21	65.6%
		Total Routine	157	97	61.8%

REGION	CALL TYPE	PROVIDER TYPE	PROVIDERS SURVEYED	TOTAL APPOINTMENTS	PLAN COMPLIANCE RATE
3	Routine	Internist/Family Practitioner	32	23	71.9%
		Pediatrician	13	7	53.8%
		OB/GYN	17	8	47.1%
		Total Routine	62	38	61.3%
	Non-Urgent "Sick"	Internist/Family Practitioner	24	7	29.2%
		Pediatrician	9	4	44.4%
		OB/GYN	13	5	38.5%
		Total Routine	46	16	34.8%
	After Hours Access	Internist/Family Practitioner	12	5	41.7%
		Pediatrician	4	4	100.0%
		OB/GYN	7	6	85.7%
		Total Routine	23	15	65.2%

Providers who were surveyed and failed will be contacted by Molina. Failed providers are subject to a Corrective Action Plan (CAP) or the option to close their panel status to new/ existing members. The failed providers will be resurveyed to determine compliance with their submitted CAP.

Appointment Availability Guidelines

- **Emergency Care**: Immediately upon presentation at a service delivery site.
- **Urgent Care**: Within twenty-four (24) hours of request.
- **Non-Urgent "Sick" Visit**: Within forty-eight (48) to seventy-two (72) hours of request.
- **Routine Appointments**: Within four (4) weeks of request.
- **Specialist Referrals (not urgent):** Within four (4) to six (6) weeks of request.
- **Initial Prenatal Visit**: Within three (3) weeks during first trimester, two weeks during the second trimester, and one week thereafter.
- **Adult Baseline and Routine Physicals**: Within twelve (12) weeks from enrollment.
- **Well Child Care**: Within four (4) weeks of request.
- **Initial Family Planning Visits**: Within two weeks of request.
- **In-Plan Mental Health or Substance Abuse Follow-Up** Visits (pursuant to an emergency or hospital discharge): within five (5) days of request, or sooner as clinically indicated.
- **In-Plan, Non-Urgent Mental Health or Substance Abuse Visits**: Within two (2) weeks of request.
- **Initial PCP Office Visit for Newborns**: Within two (2) weeks of hospital discharge.

Behavioral Health Appointment Availability Guidelines

Type of Care Required	Definition	Scheduled Appointment Timeframe
Emergency Care (Emergent)	An emergency appointment for life threatening mental health or SUDs (e.g., suicidal intent) or for non-life-threatening mental health or SUDs that nevertheless necessitate immediate intervention (e.g., psychosis).	Requires immediate face-to-face medical care. The member, designated representative, or care manager should call 911.
Urgent Care	An urgent appointment for an acute mental health or SUD, or a condition that may become an emergency if not treated (e.g., acute major depression and acute panic disorder).	Requires an appointment within 24 hours.
Follow-Up for Emergency/ Hospital Discharge	An appointment for a follow-up visit related to an emergency room or hospital discharge for evaluation of acute mental health condition.	Requires an appointment within 5 days of the member's request or as clinically indicated, but no later than 7 days post discharge.
Routine Care	An appointment for specific mental health or substance abuse concerns not of an urgent nature, i.e., marital problems, tensions at work and general anxiety disorder.	Requires an appointment within 10 business days of the member's request.

How does the Molina Quality Department work for you?

Molina is dedicated to providing the highest quality of care to our members. Molina has several resources available to assist in accomplishing this goal.

- Gaps in Care – will be made available in the provider portal, but also distributed and reviewed by the Quality Department within the provider offices
- Member rosters identifying new members, active members and terminated members, accessible from the future provider portal
- Education resources – one-on-one education sessions and written resources for HEDIS measures and appropriate coding are available
- Assistance with outreach to Molina members for scheduling appointments and reminder calls
- Embedded Molina staff to assist provider offices with outreach and education
- Customized program development in collaboration with the Quality Department
- Provider incentives available for compliance with HEDIS measures

While Molina is focused on all aspects of Quality of Care, we have been focusing on well care, prevention screenings, and prenatal/postpartum care. We have implemented provider incentives for multiple measures including well child and preventive office visits, breast and cervical cancer screenings, and prenatal and postpartum care for those provider groups not on a value based contract.

For inquiries on how our Quality Department can assist you, please contact the Molina Quality Department at MHNYQualityDepartment@Molinahealthcare.com or call Provider Services at (877) 872-4716 and ask to be transferred to the Quality Department.

REMINDER: Coverage of Medical Language Interpreter Services

(https://www.health.ny.gov/health_care/medicaid/program/update/2012/2012-10.htm#cov)

Effective October 1, 2012, Medicaid fee-for-service will reimburse Article 28, 31, 32 and 16 outpatient departments, hospital emergency rooms (HERs), diagnostic and treatment centers (D&TCs), federally qualified health centers (FQHCs) and office-based practitioners to provide medical language interpreter services for Medicaid members with limited English proficiency (LEP) and communication services for people who are deaf and hard of hearing. Effective December 1, 2012, medical language interpreter services will also be reimbursed by Medicaid Managed Care and Family Health Plus plans in accordance with rates established in provider agreements or, for out-of- network providers, at negotiated rates

HCPCS Procedure Code T1013	Office-Based Practitioners	Article 28, 31, 32 and 16 facilities that bill with APGs
One Unit: Includes a minimum of eight and up to 22 minutes of medical language interpreter services	$11.00	$11.00
Two Units: Includes 23 or more minutes of medical language interpreter services	$22.00	$22.00

Patients with limited English proficiency shall be defined as patients whose primary language is not English and who cannot speak, read, write or understand the English language at a level sufficient to permit such patients to interact effectively with health care providers and their staff.

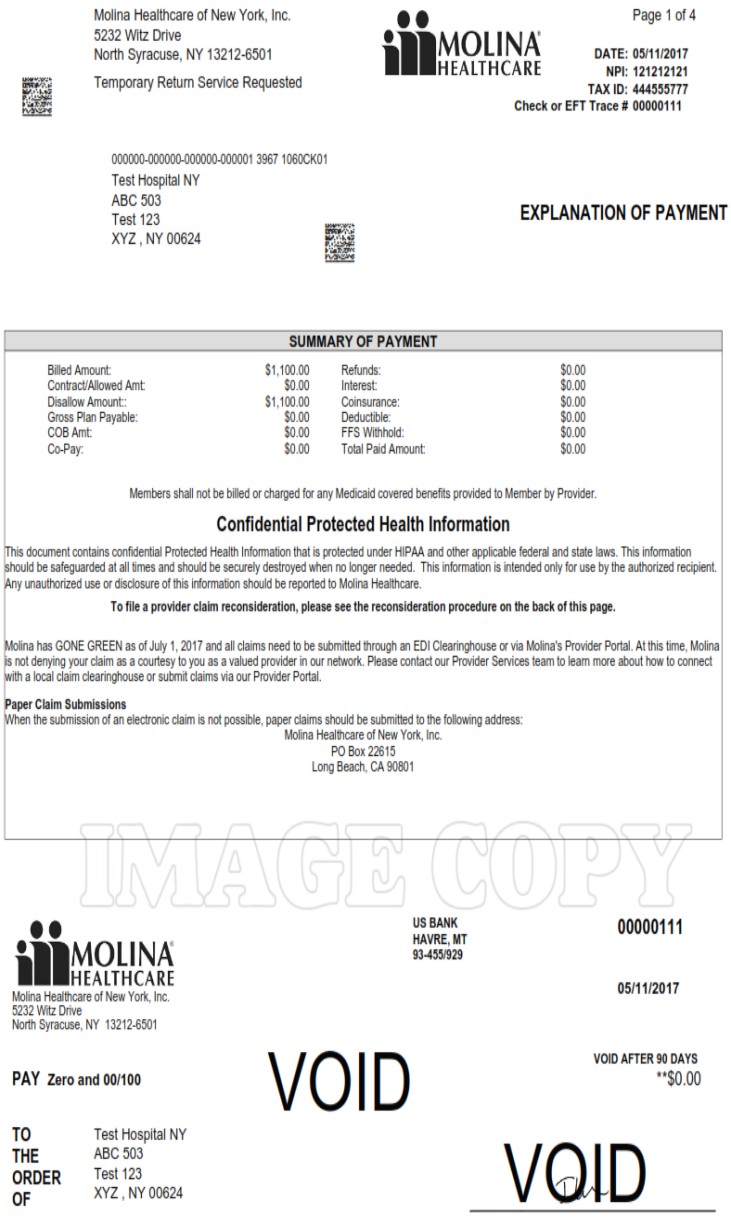
The need for medical language interpreter services must be documented in the medical record and must be provided during a medical visit by a third party interpreter, who is either employed by or contracts with the Medicaid provider. These services may be provided either face-to-face or by telephone. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be recognized by the National Board of Certification for Medical Interpreters (NBCMI). Reimbursement of medical language interpreter services is payable with HCPCS procedure code T1013- sign language and oral interpretation services and is billable during a medical visit. Medical language interpreter services are included in the prospective payment system rate for those FQHCs that do not participate in APG reimbursement.

Questions? Please contact the Division of Program Development and Management at (518) 473-2160.

Call Center

On 7/10/2017, Molina's local call center was transitioned to a new call logging system. This has significantly increased hold times, due to the staff training. As we continuously strive for better service to our providers, we ask for your understanding. If you have questions on member eligibility or claim status, you can email the following mailbox, and our enrollment team will get back you quickly. MHNYEnrollment@molinahealthcare.com

Sample Explanation of Payment (EOP)



Molina Healthcare of New York, Inc.
5232 Witz Drive
North Syracuse, NY 13212-6501
Temporary Return Service Requested

MOLINA HEALTHCARE

Page 1 of 4

DATE: 05/11/2017
NPI: 121212121
TAX ID: 444555777
Check or EFT Trace # 00000111

000000-000000-000000-000001 3967 1060CK01
Test Hospital NY
ABC 503
Test 123
XYZ , NY 00624

EXPLANATION OF PAYMENT

SUMMARY OF PAYMENT

Billed Amount:	$1,100.00	Refunds:	$0.00
Contract/Allowed Amt:	$0.00	Interest:	$0.00
Disallow Amount::	$1,100.00	Coinsurance:	$0.00
Gross Plan Payable:	$0.00	Deductible:	$0.00
COB Amt:	$0.00	FFS Withhold:	$0.00
Co-Pay:	$0.00	Total Paid Amount:	$0.00

Members shall not be billed or charged for any Medicaid covered benefits provided to Member by Provider.

Confidential Protected Health Information

This document contains confidential Protected Health Information that is protected under HIPAA and other applicable federal and state laws. This information should be safeguarded at all times and should be securely destroyed when no longer needed. This information is intended only for use by the authorized recipient. Any unauthorized use or disclosure of this information should be reported to Molina Healthcare.

To file a provider claim reconsideration, please see the reconsideration procedure on the back of this page.

Molina has GONE GREEN as of July 1, 2017 and all claims need to be submitted through an EDI Clearinghouse or via Molina's Provider Portal. At this time, Molina is not denying your claim as a courtesy to you as a valued provider in our network. Please contact our Provider Services team to learn more about how to connect with a local claim clearinghouse or submit claims via our Provider Portal.

Paper Claim Submissions
When the submission of an electronic claim is not possible, paper claims should be submitted to the following address:
Molina Healthcare of New York, Inc.
PO Box 22615
Long Beach, CA 90801

IMAGE COPY

MOLINA HEALTHCARE
Molina Healthcare of New York, Inc.
5232 Witz Drive
North Syracuse, NY 13212-6501

US BANK
HAVRE, MT
93-455/929

00000111

05/11/2017

PAY Zero and 00/100

VOID

VOID AFTER 90 DAYS
**$0.00

TO THE ORDER OF
Test Hospital NY
ABC 503
Test 123
XYZ , NY 00624

VOID

Appeal Procedures

CLAIM ADJUSTMENTS

- A request for a claim adjustment must be received within 120 days of the date on the Explanation of Payment (EOP). The provider must attach supporting documented and/ or corrected claim along with a completed "Claim Adjustment Request Form" (www.molinahealthcare.com).

  Submit to:

  Fax: 315-234-9812
  Attention: PIRR Department

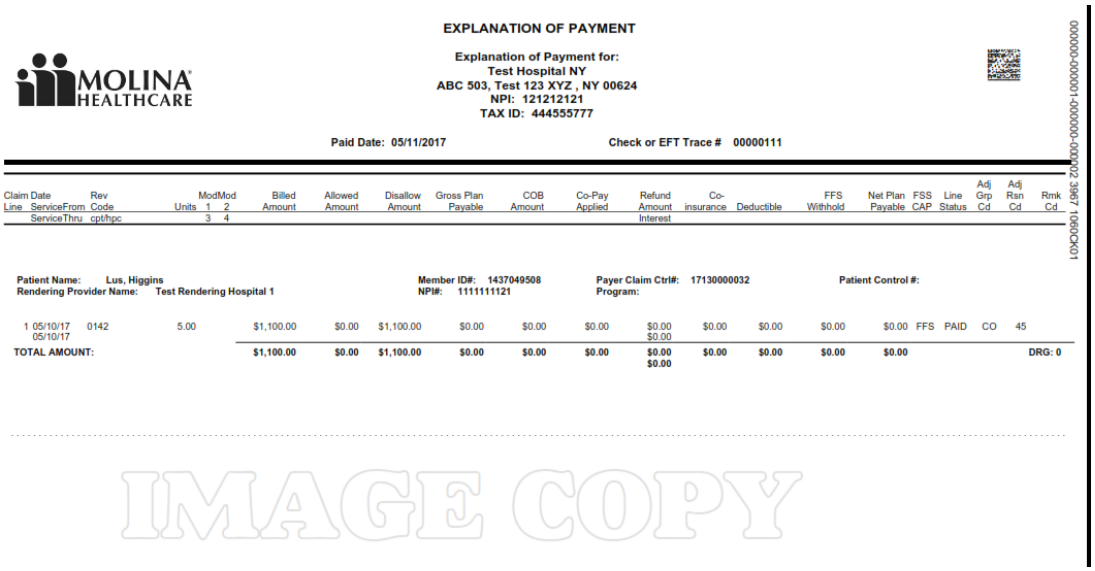
  Mail: Molina Healthcare of New York, Inc.
  Attention: PIRR Department
  5232 Witz Drive
  North Syracuse, NY 13212-6501

CLAIM APPEALS

- If a provider disagrees with a claim denial or claim payment (under or over), the provider must attach documentation supporting their position/ payment along with a completed "Provider Appeal Request Form" (www.molinahealthcare.com) within 60 working days of the date of denial on the Explanation of Payment (EOP). Appeals after that time will be denied for untimely filing. If the provider feels they have filed the appeal within the noted timeframe, the provider may submit documentation showing proof of timely submission.

  Submit to:

  Molina Healthcare of New York, Inc.
  Attention: Appeals & Grievances Department
  5232 Witz Drive
  North Syracuse, NY 13212-6501



MOLINA HEALTHCARE

EXPLANATION OF PAYMENT

Explanation of Payment for:
Test Hospital NY
ABC 503, Test 123 XYZ , NY 00624
NPI: 121212121
TAX ID: 444555777

Paid Date: 05/11/2017 **Check or EFT Trace # 00000111**

000000-000001-000000-0000022 3967 1060DK001

Claim Line	Date ServiceFrom ServiceThru	Rev Code cpt/hpc	Units	Mod 1 3	Mod 2 4	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan Payable	COB Amount	Co-Pay Applied	Refund Amount Interest	Co-insurance	Deductible	FFS Withhold	Net Plan Payable	FSS CAP	Line Status	Adj Grp Cd	Adj Rsn Cd	Rmk Cd
1	05/10/17 05/10/17	0142	5.00			$1,100.00	$0.00	$1,100.00	$0.00	$0.00	$0.00	$0.00 $0.00	$0.00	$0.00	$0.00	$0.00	FFS	PAID	CO	45	
TOTAL AMOUNT:						**$1,100.00**	**$0.00**	**$1,100.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00** **$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**					**DRG: 0**

Patient Name: Lus, Higgins
Rendering Provider Name: Test Rendering Hospital 1
Member ID#: 1437049508
NPI#: 1111111121
Payer Claim Ctrl#: 17130000032
Program:
Patient Control #:

MOLINA HEALTHCARE

EXPLANATION OF PAYMENT

Explanation of Payment for:
Test Hospital NY
ABC 503, Test 123 XYZ , NY 00624
NPI: 121212121
TAX ID: 444555777

Paid Date: 05/11/2017 **Check or EFT Trace # 00000111**

Claim Line	Date ServiceFrom ServiceThru	Rev Code cpt/hpc	Units	Mod 1 3	Mod 2 4	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan Payable	COB Amount	Co-Pay Applied	Refund Amount Interest	Co-insurance	Deductible	FFS Withhold	Net Plan Payable	FSS CAP	Line Status	Adj Grp Cd	Adj Rsn Cd	Rmk Cd

DESCRIPTION OF HIPAA ADJUSTMENT & REMARK

ADJ GRP CODE	DESCRIPTION
CO	Contractual Obligation

ADJ RSN CODE	DESCRIPTION
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)

Network Management & Ops
5232 Witz Dr.
North Syracuse, NY 13212

Please contact Network Management & Ops at:

(877) 872-4716

(844) 879-4509

Monday – Friday,
8:00am - 5:00pm.

Email: MHNYProviderServices@Molinahealthcare.com

MolinaHealthcare.com

Your Extended Family.

6901021NY0717