Making the Connection

Provider Newsletter • 4th Quarter 2017

Special Update!
2018 Wisconsin Marketplace Exit

Dear Provider Community,

Molina Healthcare of Wisconsin, Inc. ("Molina") has recently conducted an extensive analysis concerning the viability of our continued participation in the Health Insurance Marketplace (also referred to as "Marketplace") in Wisconsin. After months of consideration and difficult conversations, Molina has made the decision to exit the Wisconsin on-exchange market, effective December 31, 2017.

Molina Healthcare of Wisconsin, Inc. will continue to offer Medicare and Medicaid products in Wisconsin, allowing us to focus on servicing the needs of the core populations that Molina was founded upon.

We are dedicated to making this transition as smooth as possible as we discontinue our Marketplace offering, and we are committed to meeting the ongoing needs of our Marketplace members through December 31, 2017.

Thank you for your understanding of this decision and your continued efforts to be a valuable partner.

Scott Johnson
Plan President
Molina Healthcare of Wisconsin, Inc.

Please note Molina Healthcare will continue to serve our Medicare and Medicaid lines of business in Wisconsin. We appreciate your continued partnership serving these members and thank you for your assistance transitioning our Marketplace members.

Contents

Marketing Policies for Providers in Molina's BadgerCare Plus and Medicaid SSI HMO Network

The Wisconsin Department of Health Services (DHS) recently released an "Outreach and Communication Guide" which outlines allowable communication and outreach practices when health maintenance organizations (HMOs) and HMO-contracted providers communicate with HMO members and potential members. While much of the guide focuses on policies regarding how HMOs communicate with their members and potential members, there are some policies which affect Molina's contracted providers.

Here are reminders about what Molina's contracted providers can and cannot do when it comes to communicating with Medicaid enrollees about HMOs:

- Providers are allowed to educate/inform their patients about the BadgerCare Plus and Medicaid SSI HMOs with which they contract.
- Providers are allowed to inform their patients of the benefits, services, and specialty care services offered through the HMOs in which they participate.
- Providers are allowed to give a patient contact information for a particular HMO, but only at the patient's request.
- Providers are allowed to assist potentially eligible individuals with enrollment in the BadgerCare Plus and/or Medicaid SSI programs by helping them:

    - Apply online at the Access website: www.access.wisconsin.gov;
    - Complete the online form at: www.dhs.wisconsin.gov/forms/F1/F10182.pdf; or
    - Call or go to their county IM agency or tribal agency to complete an application; for a map of the different IM agencies per county, go to: www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm.

- Providers are allowed to assist potentially eligible individuals with the BadgerCare Plus express enrollment process, as described on the ForwardHealth Portal at www.forwardhealth.wi.gov, if they qualify.
- Providers are allowed to refer patients with questions about the BadgerCare Plus and/or Medicaid SSI programs to an HMO Enrollment Specialist at (800) 291-2002.
- HMOs are allowed to conduct orientations, health fairs, or community baby showers for their members in a private setting at a provider's office.
- Providers are prohibited from recommending one HMO over another HMO, offering patients incentives to select one HMO over another HMO, or assisting the patient in deciding to select a specific HMO.

If there are any questions about these policies, please contact WIproviderengagement@molinahealthcare.com.

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Convenience Care Clinics

Important reminder! Services rendered in a walk-in retail convenient care clinic are suitable for treatment of minor acute conditions, limited preventive services and vaccines. Please be mindful that Medicaid allows reimbursement only for members aged 6 years and older when rendered by a Medicaid-enrolled nurse practitioner, physician assistant, or physician in a walk-in retail or convenient care clinic.

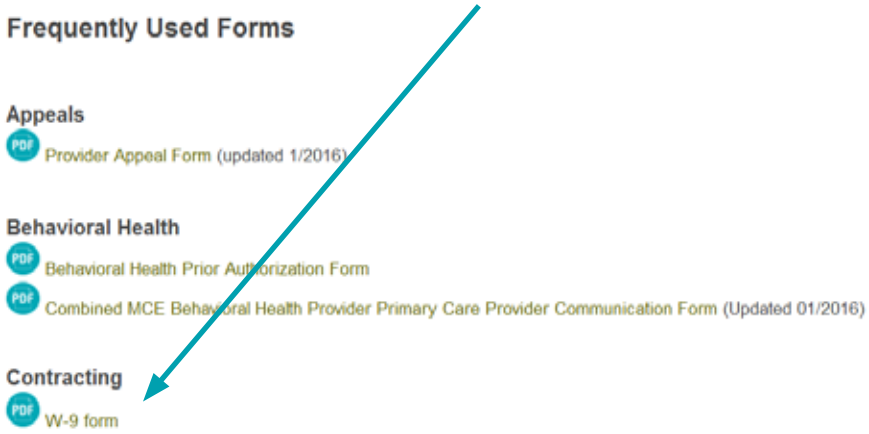
Please refer to Forward Health topic #17457 to learn more.
https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Print.aspx?ia=1&p=1&sa=50&s=2&c=61&nt=Services+Rendered+in+Walk-In+Retail+or+Convenient+Care+Clinics

Reminder- Updating W-9's

Molina Healthcare requires all providers to have a current W-9 Form on file certifying your Taxpayer Identification Number (TIN). This document is issued by the United States Internal Revenue Service (IRS). Molina Healthcare uses it to update information such as; TIN Owner Name, DBA Name and Tax ID's when received with a Provider Information Update Form. The business name, address and tax identification number must match your claims and should contain the business name as it appears on your W-9. If the W-9 does not match your claims we may be unable to process your claims.

For your convenience, you can download a W-9 Form and Provider Information Update Form from:
http://www.molinahealthcare.com/providers/wi/medicaid/forms/Pages/fuf.aspx.

Located under the Contracting section



Updated W-9 and Provider Information Update Forms can be faxed to (414) 214-2481, Attention: Provider Services or email to WIProviderEngagement@MolinaHealthcare.com.

MolinaHealthcare.com

Transitions of Care Program

Molina Healthcare of Wisconsin offers an important member-centric program called Transitions of Care (TOC). This program is staffed by TOC coaches - Registered Nurses and Social Workers with experience in case management, behavioral health, and healthcare. The four to six week intervention is designed to provide an added layer of support for Molina members who are at risk and experience hospitalizations, whether planned or unplanned. Molina members currently in an inpatient setting are eligible for TOC with the emphasis on targeted conditions of diabetes, asthma, COPD, CHF, cellulitis, pneumonia and behavioral health conditions.

The program begins with the TOC coach contacting the member in the hospital, whether telephonically or in person, to establish rapport and offer support. Throughout the program, discharge instructions are reinforced, medications are reviewed, and upcoming appointments are confirmed or coordinated. In addition, important topics such as medication adherence, follow-up appointments, food insecurity, housing and transportation will be revaluated. Additional interventions may focus around attending provider visits to assist Molina members with creating and understanding the agreed upon plan for care. If the member would continue to benefit from support upon the end of the intervention, a referral to ongoing case management or other services will be provided. For more information on the TOC program, or to make a referral, please contact Sara Morgan at (414) 882-2952.

What is the National Diabetes Prevention Program?

This program is designed to help adults that are at high risk for type 2 diabetes learn skills to eat healthier and be more active. This is a CDC recognized lifestyle change program focused on delaying the onset of Type II Diabetes.

This program meets once per week for 1 hour sessions for 16 weeks. After the initial 16 weeks the participants meet once per month for 6 months.

Who should you send to this program?
Your patients who:

- Are 18 years or older AND
- Have a BMI ≥ 24 kg/m2 (≥22 if Asian) AND
- A diagnosis of pre-diabetes, or GDM, based on one or more
  - Fasting blood glucose (range 100 - 125 mg/dl)
  - 2-hour glucose (range 140 - 199 mg/dl)
  - HbA1c (range 5.7 - 6.4)
  - Previous GDM (may be self-reported)

How do I refer my Patients?
Please contact Amanda Silverthorn or Chelsea Hoffman at (414) 755-5155 or fax the attached referral form to (414) 214-2488.

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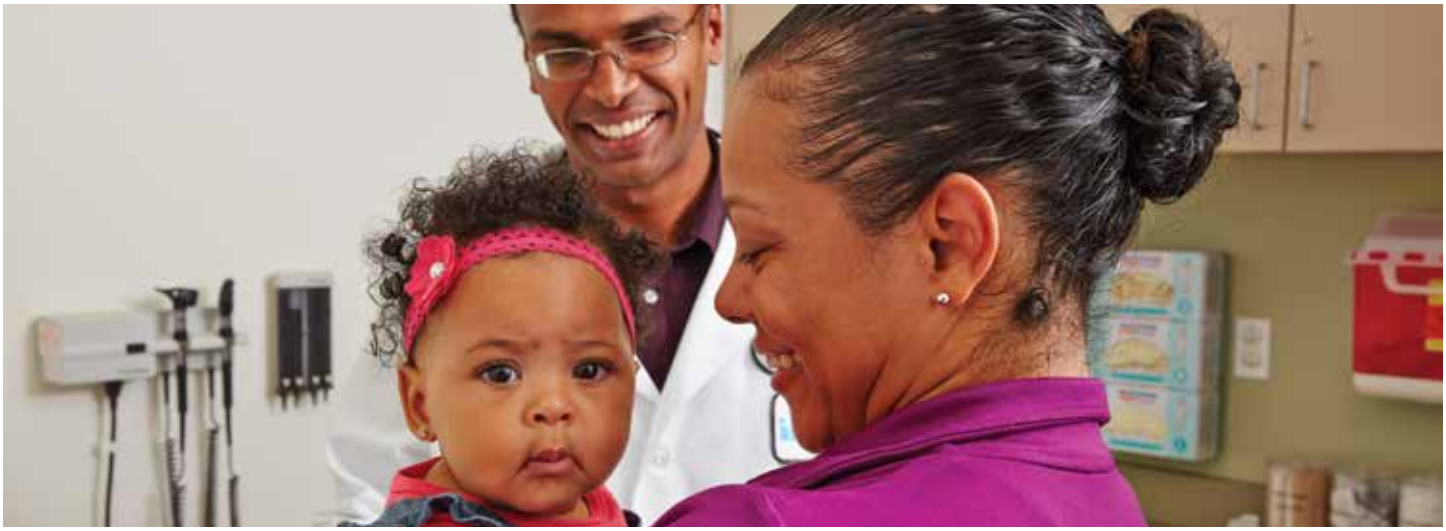

Flu Season is upon us…

Please help us keep our patients healthy. Please educate your patients on the importance of the flu vaccination, and encourage them to receive it.

As you know, the flu vaccine is the best defense against the flu, possible complications, and the potential to spread to others.

Please check the Center for Disease Control and Prevention (CDC) website for more details on what's new for the 2016-2017 flu season, this can be found at the following link http://www.cdc.gov/flu/about/season/flu-season-2016-2017.htm.

Thank you for the care you give our members and your partnership in keeping our community healthy!

2017 Model of Care

The Centers for Medicare and Medicaid (CMS) requires that all Molina contracted providers complete the annual Model of Care (MOC) training, no later than December 1, 2017.

This basic training reviews the Molina Healthcare duals program and describes how Molina Healthcare and its contracted providers work together to successfully deliver the duals MOC program.

To view the 2017 Model of Care Provider Training please visit:
http://www.molinahealthcare.com/providers/common/medicare/Pages/medicare.aspx.

Once you have completed the training please complete the 2017 Model of Care Provider Training Attestation form. The completed form can be faxed to your Provider Representative at (414) 214-2481 or emailed to WIProviderEngagement@MolinaHealthcare.com.

MolinaHealthcare.com

Provider Orientation Webinars

Molina Healthcare of Wisconsin's Provider Education Webinars are open to all Network Providers, their medical and office staff. Webinars are hosted through WebEx, which allows you to listen to the presentation by phone or by viewing it on your computer. Webinars include a live person and subject matter expert to answer your questions.

November			December		
Thursday 11/2/2017 https://molina.webex.com/molina/j.php?MTID=m892baa81bd3e-a4538b010d8071f20637	10:00 AM	Provider Orientation	Tuesday 12/5/2017 https://molina.webex.com/molina/j.php?MTID=mcf-9c3a3903048247e93d1c-de9c460298	10:00 AM	Provider Orientation
Tuesday 11/7/2017 https://molina.webex.com/molina/j.php?MTID=m2ccd-9b3a95621b7dbff2b8e4f2886802	10:00 AM	Provider Orientation	Thursday 12/14/2017 https://molina.webex.com/molina/j.php?MTID=mac910b1abdff-c2201e2fd9192d783bf8	10:00 AM	Provider Orientation
Thursday 11/16/2017 https://molina.webex.com/molina/j.php?MTID=m6cd-f8ad80a7770818a82ad5cdc30c660	10:00 AM	Provider Orientation	Tuesday 12/19/2017 https://molina.webex.com/molina/j.php?MTID=mdb77ebc-47428cfe09c737c75d673cf49	10:00 AM	Provider Orientation
Tuesday 11/21/2017 https://molina.webex.com/molina/j.php?MTID=mc947e0b10223d-04175648d7c7ceb1e2e	10:00 AM	Provider Orientation	Thursday 12/28/2017 https://molina.webex.com/molina/j.php?MTID=m549900ff65b5774a8c-b45a40933062fd	10:00 AM	Provider Orientation
Thursday 11/30/2017 https://molina.webex.com/molina/j.php?MTID=m90621f16966c-25c1199e704ee23334ef	10:00 AM	Provider Orientation			

Please encourage appropriate staff to register for these informative, educational opportunities.
Please e-mail WIProviderEngagement@Molinahealthcare.com to be added to our e-mail list and be the first to learn about new webinars.

MolinaHealthcare.com

Molina Healthcare Prior Authorization Requirements

Molina requires prior authorization for certain services, procedures, surgeries, devices, supplies, drugs and other treatment. Molina does not require an authorization for a referral to a specialist, if the specialist is an in-network provider for the specific line of business. Referrals to specialty care providers outside of the network require prior authorization.

Molina maintains a specific list of prior authorization requirements that is available to all Molina contracted providers via the provider manual and the Molina website. Coverage is not authorized until the request has been reviewed and approved by the Molina Healthcare services Department. Certain services do not require prior authorization. Some services are not a covered benefit.

Please refer to the following links for each line of business to determine if the service is a covered benefit.

- **Medicare** - CMS website https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.
- **Medicaid** - Forward Health website - https://www.forwardhealth.wi.gov/WIPortal/Default.aspx.
- **Marketplace** - Molina Healthcare website Specific EOC http://www.molinahealthcare.com/providers/wi/medicaid/Pages/home.aspx.

Providers may submit requests for prior authorization via fax to (877) 708-2117. Requests for services will be handled by Molina's Healthcare Services department when:

- The request for services is a new request.
- The request for a service that had a previous adverse determination and the date of the request is more than 60 days from the submission of the original request.

All requests for authorization will be handled as expeditiously as the member's health condition requires, no later than 14 days following the date of receipt of the request of service. Urgent requests will be handled with 72 hours of receipt.

If an authorization request is denied, the provider will have 5 business days to submit additional information for reconsideration or request to schedule a peer to peer review by calling (414) 214-2495 ext. 302665. Authorization requests for services that are not a covered benefit will be administratively denied. These types of denials will not be eligible for a peer to peer/reconsideration as they are a non-covered benefit. Please refer to the websites above for each line of business to determine if the service is a covered benefit.

Emergency Department
Visits to the emergency room do not require an authorization, however, if the member is admitted to inpatient status the facility must notify Molina within 24 hours of the admission or by the next business day.

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Inpatient Authorization
Notification of an inpatient admission is required within 24 hours of the admission or the next business day. Molina Healthcare requires that members must meet inpatient medical necessity criteria during their stay in order to qualify for inpatient status. All inpatient requests will be reviewed for the most appropriate level of care included but not limited to observation level of care. Level of care will be reviewed throughout the inpatient stay. The facility needs to notify Molina of a change of level of care (i.e. observation to inpatient, ICU to medical or telemetry to medical etc.). Molina will use a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is updated regularly, and is reviewed and approved annually. CMS and state regulations, Molina clinical policies, and benefit guidance will be used as well as nationally accepted evidence based criteria guidelines such as InterQual or MCG criteria.

Updating Provider Information

Molina Healthcare requires Providers to notify us in writing, by fax or e-mail with any of the following changes:

- Changes in practice ownership, name, address, phone number or Federal Tax ID numbers.
- When adding a new physician to the practice or if a physician is leaving the practice.
- Upon loss or suspension of your license to practice.
- In the event of bankruptcy or insolvency.
- In the event of any suspension, exclusion, debarment, or other sanction from a State or federally funded healthcare program.
- In the event of any indictment, arrest, conviction for a felony, or any criminal charge related to your practice.
- If there are any material changes in cancellation or termination of liability insurance.
- If or when you are closing your practice to new patients and vice versa.
- At **least 90** days before terminating affiliation with Molina Healthcare of Wisconsin or one of its provider networks (refer to your contract for specific termination terms).

Please submit changes via mail, fax, or e-mail:
Molina Health Care of Wisconsin
11200 West Parkland Avenue
Milwaukee, WI 53224-3127
FAX: (414) 214-2481

E-MAIL: WIProviderEngagement@MolinaHealthcare.com

Pregnancy and Oral Health

Please encourage pregnant patients to see a dentist during pregnancy. Regular preventative visits before or during pregnancy helps avoid periodontal disease. Good oral health during pregnancy is important for developing babies.

MolinaHealthcare.com

Risk Adjustment- Thank you!

Molina Healthcare of Wisconsin would like to thank all our providers who participated in our Annual Comprehensive Exam (ACE) program for 2017.

If you have any questions regarding Risk Adjustment please contact our Risk Adjustment Department @ WIRiskAdjustment@MolinaHealthcare.com

Important Medicaid Reminder! General Prohibition on Billing Molina's BadgerCare Plus and Medicaid Member's

Under state and federal laws, a Medicaid-enrolled provider may not collect payment from a member, or authorized person acting on behalf of the member, for covered services even if the services are covered but do not meet program requirements. Denial of a claim by Molina does not necessarily render a member liable. However, a covered service for which a prior authorization (PA) was denied is treated as a non-covered service. (If a member chooses to receive an originally requested service instead of the service approved on a modified PA request, it is also treated as a non-covered service.) If a member requests a covered service for which PA was denied (or modified), the provider may collect payment from the member if certain conditions are met.

A member may request a non-covered service, a covered service for which PA was denied (or modified), or a service that is not covered under the member's limited benefit category. The charge for the service may be collected from the member if the following conditions are met prior to the delivery of that service:

- The member accepts responsibility for payment.
- The provider and member make payment arrangements for the service.

Providers are strongly encouraged to obtain a written statement in advance documenting that the member has accepted responsibility for the payment of the service.

Furthermore, the service must be separate or distinct from a related, covered service. For example, a vision provider may provide a member with eyeglasses but then, upon the member's request, provide and charge the member for anti-glare coating, which is a non-covered service. Charging the member is permissible in this situation because the anti-glare coating is a separate service and can be added to the lenses at a later time.

Related to cost-sharing, according to federal regulations, providers cannot hold a member responsible for any commercial or Medicare cost-sharing amount such as coinsurance, copayment, or deductible. Therefore, a provider may not collect payment from a member, or authorized person acting on behalf of the member, for copayments required by other health insurance sources. Instead, the provider should collect from the member only the Medicaid or BadgerCare Plus copayment amount indicated on the member's remittance information.

If a provider collects payment from a member, or an authorized person acting on behalf of the member, for a covered service, the provider may be subject to program sanctions including termination of Medicaid enrollment.

If there are any questions about these policies, please see ForwardHealth Provider Handbook Topics 86, 227, and 538 or contact WIproviderengagement@molinahealthcare.com.

Network Updates

DME Rental Items – Forward Health Topic # 1729
Rental items billed (RR modifier) must have "from" and "to" DOS. If the item was provided on consecutive days, those dates may be indicated as a range of dates by entering the first date as the "from" DOS and the last date as the "to" DOS. The number of days indicated must equal the number of days within the range. Rental items must be ranged within the same calendar month per detail line. This means if rental is billed from 1/15/2017 to 2/15/2017 the item must be entered onto 2 separate claim lines to indicate DOS for 1/15/2017 to 1/31/2017 and 2/1/2017 to 2/15/2017 with the appropriate units per day.

Outpatient Submissions – EAPG has given us a new set of rules for Medicaid Outpatient facility claim submission. Beginning 1/1/2015 providers billing OP facility services must submit all charges for the same date of service on one claim. If there are services that are unrelated to the original visit the provider must indicate a condition code G0 (zero) - Distinct medical visit on the second claim submitted. As an example the member has an MRI performed for headaches and ordered from Dr. Smith and then return later in the same day to the ER due to a fall. These services are unrelated and the second claim should be submitted with a G0 modifier. Please see the attached link from Forward Health;
https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspxia=1&p=1&sa=43&s=4&c=13&nt=Dates+of+Service+and+Multiple+Visits.

The denial the providers will receive will state, "Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO). "Unfortunately with our system limitations this is the best denial code we can map to at this time. Please be aware when you receive this denial on outpatient facility claims you will need to determine if a G0 condition code is appropriate to indicate an unrelated service from previous billing or if a corrected claim should be submitted, combining all charges from the same date of service. Please watch claims that span DOS and remember that all services are required to be on one claim; watch if individual billings were already submitted for specific DOS.

Outpatient therapy services – Forward Health update https://www.forwardhealth.wi.gov/kw/pdf/2011-76.pdf (2011-76) states that providers billing services for Medicaid outpatient hospital physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) services are reminded to submit claims using a professional claim (CMS-1500) to receive reimbursement. The exceptions to this requirement are;

- Claims for PT, OT, and SLP evaluations and reevaluations provided on the same DOS as an outpatient hospital specialty clinic visit.
- Claims for PT and OT services provided during an outpatient hospital (as defined above) cardiac rehabilitation visit, with cardiac rehabilitation team monitoring or physician electrocardiographic monitoring also provided.
- Provider-submitted Medicare crossover claims for outpatient hospital PT, OT, and SLP services previously submitted to Medicare on an institutional claim.

Day Treatment Claims – For Medicaid claim reimbursement, day treatment must be submitted on a CMS-1500 per the requirements set by Forward Health.

Laboratory services – As a reminder, provider contracts require use of participating providers. This includes laboratory services. Providers are required to submit specimens to participating laboratories. A complete list of participating laboratories can be found at;
http://www.molinahealthcare.com/providers/wi/medicaid/Pages/home.aspx

Office Visit Procedure G0463 – Providers, please note that Medicare procedure G0463 is an office visit procedure that's used for Medicare and Marketplace billing when services are part of Hospital Clinic based billing. However, this procedure should not be utilized for Medicaid claim submissions if the member does not have a Medicare primary plan. Medicaid claims are required to bill the standard office visit procedure codes from the CPT book based on the documentation of the visit.

Don't Miss out! Join our E-Mail Distribution List

To receive this newsletter via e-mail, send an e-mail to WIProviderEngagement@MolinaHealthcare.com.

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