MOLINA HEALTHCARE

PROVIDER BULLETIN

A bulletin for the Molina Healthcare of Ohio Medicaid and Medicare-Medicaid Networks

APRIL 2015

IN THIS ISSUE

PATIENTS' MEDICAID RENEWAL DEADLINE MAY BE SOON

It may be time for your Medicaid and MyCare Ohio patients to renew their Medicaid eligibility. For your patients to keep their Medicaid and MyCare Ohio health benefits, they have to report their income to the County Department of Job and Family Services (CDJFS/JFS) every 12 months.

The Ohio Department of Medicaid (ODM) mailed letters to 350,000 Ohio Medicaid recipients informing them that if they do not verify their household income, therefore redetermining their eligibility for Medicaid, their Medicaid benefits will be terminated. *Tens of thousands* of Ohioans could lose their health care benefits if they do not report their income.

Last year, the renewal process was suspended in order to focus on Medicaid expansion and the launch of benefits.ohio.gov. As a result, many of your Medicaid or MyCare Ohio patients are likely unfamiliar with the renewal process, and Molina Healthcare is increasing outreach efforts to inform these members. Please remind your Medicaid and MyCare Ohio patients of the importance of reporting their income to their local county JFS office. Your patients who have already redetermined their Medicaid eligibility in the past 12 months do not have to go back to their county JFS office. To find contact information for JFS offices listed by county, visit www.jfs.ohio.gov and click on "County Directory."

If you or your patients have any questions about Medicaid redetermination, call your county JFS office.

ACCESS STANDARDS – HELPING MEMBERS SET REASONABLE EXPECTATIONS

Molina Healthcare has adopted the appointment availability standards below to ensure that our members have adequate access to primary care, specialty and behavioral health services. These standards are based on industry and NCQA standards (where available) and are reviewed and approved by the Molina Healthcare Executive Quality Improvement Committee (EQIC).

Molina Healthcare conducts an annual survey to measure

Questions?
Call Provider Services
(855) 322-4079 – 8 a.m. to 6 p.m.
Monday through Friday

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- → group name
- → TIN
- → service location address
- → contact name
- → contact phone number
- → email

Website Roundup
These Provider Reference Guides were added to the Molina Dual Options website at www.MolinaHealthcare.com:

- DME Quick Tips Guide
- Behavioral Health FAQs

Also updated is the Prenatal Risk Assessment Form (PRAF), which helps identify medical and psychosocial factors that could impact a member's pregnancy. These issues could lead to low birth weight, premature birth, fetal or infant death and developmental delays.

Clear Coverage™ Corner – Training
Start using Clear Coverage™ today and reap all the benefits of a web-based authorization system. It has clear advantages compared to submitting authorizations through fax or over the phone.

If you want to learn more, on-site trainings are available upon request to your Provider Services Representative. Check future issues of the Provider Bulletin for training dates and times.

compliance with appointment availability standards, performs targeted education, and implements corrective action plans with participating providers not meeting the standards.

Category	Type of Care	Access Standard
Primary care provider (general practitioners, internist, family practitioners, pediatricians)	Preventive/routine care	Six weeks
	Urgent care	By the end of the following work day
	Emergent care	Triaged and treated immediately
	After hours	Available by phone 24/7
OB/GYN	Pregnancy (initial visit)	Two weeks
	Routine visit	Six weeks
Orthopedist	Routine visit	Eight weeks
Otolaryngologist (ENT)	Routine visit	Six weeks
Dermatologist	Routine visit	Eight weeks
Dental	Routine visit	Six weeks
Endocrinologist	Routine visit	Eight weeks
Allergist	Routine visit	Eight weeks
Neurologist	Routine visit	Eight weeks
Behavioral health	Routine care	10 business days
	Urgent care	48 hours
	Non-life threatening emergency	Six hours
All other non-primary care	Routine care	Eight weeks
All	Office wait time	Maximum of 30 min.

CLAIM RECONSIDERATION POLICY UPDATE

Because Molina Healthcare is committed to superior customer service, we have extended our provider submission timeframe from 14 days to 30 days for the Medicaid line of business. The updated policy will apply to all pre-service prior authorization and post-service claim requests for reconsideration received April 1, 2015 and after.

This update does not alter a member's right to appeal or a provider's right to appeal on a member's behalf. The intent of this 30-day window is to allow providers the opportunity to submit additional clinical information for a final review.

- For pre-service denial reconsideration requests, providers will have 30 calendar days from the date of the denial notification to either request a peer-to-peer review with one of our Medical Directors or submit additional clinical information for final medical review.
- For post-service claim denial reconsideration requests, providers will have 30 calendar days from the date the post-service claim reconsideration request was initially denied to submit additional clinical information for final medical review.

The fax number to submit a Claims Reconsideration Request Form (CRRF) is (800) 499-3406. Molina Healthcare asks that providers use fax whenever possible to submit the CRRF and that a single CRRF is submitted for each member.

Update to Corrected Claims Process

Now, you can submit corrected claims directly through Molina Healthcare's Provider Web Portal. You can also still submit corrected claims in paper format.

In Box 22 and Box 22A ("Medicaid Resubmission Code" and "Resubmission Original Ref No") on CMS 1500s forms, indicate your submission is a corrected claim. You can submit corrected claims on a UB04, claim types are submitted as corrected claims where the value of 7 or 8 are located in Box 4 in the third digit of the Type of Bill [XX7 or XX8].

Corrections can be sent in an electronic format.

1. In the 2300 Loop, the CLM segment (claim information), CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:
   a) "7" – REPLACEMENT (Replacement of Prior Claim)
   b) "8" – VOID (Void/Cancel of Prior Claim)
2. In the 2300 Loop, the REF segment (claim information), must include the original claim number issued to the claim being corrected. The original claim number can be found on the remittance advice.
3. Corrected claim bill type for UB claims are billed in Loop 2300/CLM05-01.

ICD-10 Implementation Update

The fifth ICD-10 Transition Information for Providers and Staff (TIPS) is posted to the ODM ICD-10 web page under the "ICD-10 TIPS (Billing Guidance)" section at http://medicaid.ohio.gov/providers/billing/icd10. The TIPS focus on International, Classification of Diseases, Clinical Modification and Procedure Coding System.

Fighting Fraud, Waste & Abuse

Do you have suspicions of member or provider fraud? The Molina Healthcare AlertLine is available 24 hours a day, 7 days a week, even on holidays at (866) 606-3889. Reports are confidential, but you may choose to report anonymously.