Quarter 2 | 2020

Molina Matters

A newsletter for Molina Healthcare Provider Networks

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Important Message – Updating Provider Information

It is important for Molina Healthcare of Mississippi (Molina Healthcare) to keep our provider network information up to date. Up to date provider information allows Molina Healthcare to accurately generate provider directories, process claims and communicate with our network of providers. Providers must notify Molina Healthcare in writing at least 30 days in advance when possible of changes, such as:

- Change in practice ownership or Federal Tax ID number and/or NPI Number
- Practice name change
- A change in practice address, phone or fax numbers
- Change in practice office hours
- New office site location
- Primary Care Providers Only: If your practice is open or closed to new patients
- When a provider joins or leaves the practice
- Change in “Pay To” Address

Continued on next page...

Send changes to:
Email: MHMSProviderContracting@MolinaHealthcare.com
Mail: Molina Healthcare of Mississippi
188 E. Capitol St., Suite 700
Jackson, MS 39201
ATTN: Provider Services Department

Contact your Provider Services Representative at (844) 826-4335 if you have questions.

Practitioner Credentialing Rights: What You Need to Know

Molina Healthcare has a duty to protect its members by assuring the care they receive is of the highest quality. One protection is assurance that our providers have been credentialed according to the strict standards established by the state regulators and accrediting organizations. Your responsibility, as a Molina Healthcare provider, includes full disclosure of all issues and timely submission of all credentialing and re-credentialing information.

Molina Healthcare also has a responsibility to its providers to assure the credentialing information it reviews is complete and accurate. As a Molina Healthcare provider, you have the right to:

- Strict confidentiality of all information submitted during the credentialing process
- Nondiscrimination during the credentialing process
- Be notified of information obtained during the credentialing process that varies substantially from what is submitted by you
- Review information submitted from outside primary sources (e.g., malpractice insurance carriers, state licensing boards) to support your credentialing application, with the exception of references, recommendations or other peer-review protected information
- Correct erroneous information
- Be informed of the status of your application upon request by calling the Credentialing Department at (844) 826-4335
- Receive notification of the credentialing decision within 60 days of the committee decision
- Receive notification of your rights as a provider to appeal an adverse decision made by the committee
- Be informed of the above rights

For further details on all your rights as a Molina Healthcare provider, please review your Provider Manual. You may also review the provider manual on our website at www.MolinaHealthcare.com or call your Provider Services Representative for more details.

Molina Healthcare's Utilization Management

One of the goals of Molina Healthcare Utilization Management (UM) department is to render appropriate UM decisions that are consistent with objective clinical evidence. To achieve that goal, Molina Healthcare maintains the following guidelines:

- Medical information received by our providers is evaluated by our highly trained UM staff against nationally recognized objective and evidence-based criteria. We also take individual circumstances (at minimum age, comorbidities, complications, progress of treatment, psychosocial situation, home environment, when applicable) and the local delivery system into account when determining the medical appropriateness of requested health care services.
- Molina Healthcare's clinical criteria includes Change Healthcare InterQual® criteria, Hayes Directory, Medicare National and Local Coverage Determinations, applicable Medicaid Guidelines, Molina Medical Coverage Guidance Documents (developed by designated Corporate Medical Affairs staff in conjunction with Molina Healthcare physicians serving on the Medical Coverage Guidance Committee) and when appropriate, third party (outside) board-certified physician reviewers.
- Molina Healthcare ensures that all criteria used for UM decision-making are available to practitioners upon request. **To obtain a copy of the UM criteria used in the decision-making process, call our UM department (844) 826-4335.**
- As the requesting practitioner, you will receive written notification of all UM denial decisions. The notification will include the name and telephone number of the Molina Healthcare physician that made the decision. Please feel free to call him or her to discuss the case. If you need assistance contacting a medical reviewer about a case, please call the UM Department at (844) 826-4335.

It is important to remember that:

1. UM decision making is based only on appropriateness of care and service and existence of coverage.
2. Molina Healthcare does not specifically reward practitioners or other individuals for issuing denials of coverage or care.
3. UM decision makers do not receive financial incentives or other types of compensation to encourage decisions that result in underutilization.
4. Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage.
5. Medicaid members have the right to a second opinion from a qualified practitioner. If an appropriate practitioner is not available in-network, Molina Healthcare will arrange for a member to obtain the second opinion out of network at no additional cost to the member than if the services were obtained in-network.
6. Some of the most common reasons for a delay or denial of a request include:
    - Insufficient or missing clinical information to provide the basis for making the decision
    - Lack of or missing progress notes or illegible documentation
    - Request for an urgent review when there is no medical urgency

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Molina Healthcare's UM Department staff is available for inbound collect or toll-free calls during regular business hours to provide information about the UM process and the authorization of care. If you wish to speak with a member of the UM staff, please call (844) 826-4335. You may also fax a question about an UM issue to (844) 826-4335. The Medical Director is available for more complex medical decision questions and explanations of medical necessity denials. For information about pre-authorization and the exception process, please refer to the Preferred Drug List and Pharmaceutical Procedures article.

Molina Healthcare's regular business hours are Monday – Friday (excluding holidays) 8:00 a.m. – 5:00 p.m. local time. Voicemail messages and faxes received after regular business hours will be returned the following business day. Molina Healthcare has language assistance and TDD/TTY services for members with language barriers or with hearing and/or speech problems.

Preferred Drug List and Pharmaceutical Procedures

At Molina Healthcare, the Preferred Drug List (PDL) and pharmaceutical procedures are maintained by the Pharmacy and Therapeutics (P&T) Committee. This committee usually meets on a quarterly basis, or more frequently if needed. It is composed of your peers – practicing physicians (both primary care physicians and specialists) and pharmacists from areas Molina Healthcare practitioners are located. The committee's goal is to provide a safe, effective and comprehensive PDL. The P&T Committee evaluates all therapeutic categories and selects the most cost-effective agent(s) in each class. In addition, the committee reviews prior authorization procedures to ensure that medications are used safely, and in accordance with the manufacturer's guidelines and FDA-approved indications. The Committee also evaluates and addresses new developments in pharmaceuticals and new applications of counter (non-prescription drugs) and the other for prescription drugs.

Medications prescribed for Molina Healthcare members must be listed in the PDL. The PDL also includes an explanation of limits or quotas, any restrictions and medication preferences, and the process for generic substitution, therapeutic interchange and step-therapy protocols. Select medications may require prior authorization, as well as any medication not found on the listing. When there is a medically necessary indication for an exception, such as failure of the PDL choices, providers may request authorization by submitting, via fax, a Medication Prior Authorization Form or by calling the Pharmacy Prior Authorization Department for the plan. The PDL is available online at www.MolinaHealthcare.com and printed copies may be obtained by calling the Provider Services Department.

The PDL listing, processes for requesting an exception request and generic substitutions, therapeutic interchanges and step-therapy protocols are distributed to our network providers through fax and/or mail once updates are made. These changes and all current documents are posted on the Molina Healthcare website at www.MolinaHealthcare.com. More information can be obtained by contacting the Pharmacy Department at (844) 826-4335.

When there is a Class II recall or voluntary drug withdrawal from the market for safety reasons, affected members and prescribing practitioners are notified by Molina Healthcare within 30 calendar days of the Food and Drug Administration notification. An expedited process is in place to ensure notification to affected members and prescribing practitioners of Class I recalls as quickly as possible. These notifications will be conducted by fax, mail and/or telephone.

Complex Case Management

Molina Healthcare offers you and your patients the opportunity to participate in our Complex Case Management Program. Patients appropriate for this voluntary program are those who have the most complex service needs. This may include your patients with multiple medical conditions, high level of dependence, conditions that require care from multiple specialties and/or have additional social, psychosocial, psychological and emotional issues that exacerbate the condition, treatment regime and/or discharge plan

The purpose of the Molina Healthcare Complex Case Management Program is to:

- Conduct a needs assessment of the patient, patient's family, and/or caregiver
- Provide intervention and care coordination services within the benefit structure across the continuum of care
- Empower our patients to optimize their health and level of functioning
- Facilitate access to medically necessary services and ensure that they are provided at the appropriate level of care in a timely manner
- Provide a comprehensive and on-going care plan for continuity of care in coordination with you, your staff, your patient, and the patient's family

If you would like to learn more about this program, speak with a Complex Case Manager and/or refer a patient for an evaluation for this program, please call toll-free (844) 826-4335.

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Website

Featured at www.MolinaHealthcare.com:

- Clinical Practice and Preventive Health Guidelines
- Health Management Programs
- Quality Improvement Programs
- Member Rights & Responsibilities
- Privacy Notices
- Claims/Denials Decision Information
- Provider Manual
- Current Preferred Drug List & Updates
- Pharmaceutical Management Procedures
- UM Affirmative Statement (re: non-incentive for under-utilization)
- How to Obtain Copies of UM Criteria
- How to Contact UM Staff & Medical Reviewer
- New Technology
- Provider Resources for Behavioral Health, Culturally and Linguistically Appropriate Services, Diabetes and Opioid Prevention
- Cultural Competency Provider Trainings
- How to Access Language Services

If you would like to receive any of the information posted on our website in hard copy, please call (844) 826-4335.

Translation Services

We can provide information in our members' primary language. We can arrange for an interpreter to help you speak with our members in almost any language. We also provide written materials in different languages and formats. If you need an interpreter or written materials in a language other than English, please contact Molina's Member Services Department. You can also call TTD/TTY:711, if a member has a hearing or speech disability.

Patient Safety

Patient Safety activities encompass appropriate safety projects and error avoidance for Molina Healthcare members in collaboration with their primary care providers.

Safe Clinical Practice

The Molina Healthcare Patient Safety activities address the following:

- Continued information about safe office practices
- Member education; providing support for members to take an active role to reduce the risk of errors in their own care

- Member education about safe medication practices
- Cultural competency training
- Improvement in the continuity and coordination of care between providers to avoid miscommunication
- Improvement in the continuity and coordination between sites of care such as hospitals and other facilities to assure timely and accurate communication
- Distribution of research on proven safe clinical practices

Molina also monitors nationally recognized quality index ratings for facilities from:

- Leapfrog Quality Index Ratings (www.leapfroggroup.org)
- The Joint Commission Quality Check® (www.qualitycheck.org)

Providers can also access the following links for additional information on patient safety:

- The Leapfrog Group (www.leapfroggroup.org)
- The Joint Commission (www.jointcommission.org)

Hours of Operation

Molina Healthcare requires that providers offer Medicaid members hours of operation no less than hours offered to commercial members.

Non-Discrimination

As a Molina Healthcare provider, you have a responsibility to not differentiate or discriminate in providing covered services to members because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, socioeconomic status, or participation in publicly financed health care programs. Providers are to render covered services to Members in the same location, in the same manner, in accordance with the same standards and within the same time availability regardless of payer.

Member Rights and Responsibilities

Molina Healthcare wants to inform its providers about some of the rights and responsibilities of Molina Healthcare members.

Molina Healthcare members have the right to:

- Receive information about Molina Healthcare, its services, its practitioners and providers and member rights and responsibilities.
- Be treated with respect and recognition of their dignity and their right to privacy.
- Help make decisions about their health care.
- Participate with practitioners in making decisions about their health care.
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

- Verbal grievances or appeals about Molina Healthcare or the care it provides.
- Make recommendations regarding Molina Healthcare member rights and responsibilities policy.

Molina Healthcare members have the responsibility to:

- Supply information (to the extent possible) that Molina Healthcare and its practitioners and providers need in order to provide care.
- Follow plans and instructions for care that they have agreed to with their practitioners.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Keep appointments and be on time. If members are going to be late or cannot keep an appointment, they are instructed to call their practitioner.

You can find the complete Molina Healthcare Member Rights and Responsibilities statement for your state at our website (**www.MolinaHealthcare.com**). Written copies and more information can be obtained by contacting the Provider Services Department at (844) 826-4335.

Population Health (Health Education, Disease Management, Care Management and Complex Case Management)

The tools and services described here are educational support for our members. We may change them at any time as necessary to meet the needs of our members.

Molina offers programs to help our members and their families manage a diagnosed health condition. You as a Provider also help us identify members who may benefit from these programs. Members can request to be enrolled or dis-enrolled in these programs. Our programs include:

- Asthma management
- Diabetes management
- High blood pressure management
- Cardiovascular Disease (CVD) management/Congestive Heart Disease
- Chronic Obstructive Pulmonary Disease (COPD) management
- Depression management

For more information about our programs, please call: Provider Services Department at (844) 826-4335 (TTY/TDD at 711 Relay).

You can find more information about our programs on the Molina website at www.MolinaHealthcare.com.

Quality Improvement Program

The Molina Healthcare Quality Improvement Program (QIP) provides the structure and key processes that enable the health plan to carry out our commitment to ongoing improvement in members' health care and service. The Quality Improvement Committee (QIC) assists the organization to achieve these goals. It is an evolving program that is responsive to the changing needs of the health plan's customers and the standards established by the medical community, regulatory and accrediting bodies.

The key quality processes include but are not limited to:

- Implementation of programs and processes to improve members' outcomes and health status
- Collaboration with our contracted provider network to identify relevant care processes, develop tools and design meaningful measurement methodologies for provided care and service
- Evaluation of the effectiveness of programs, interventions and process improvements and determination of further actions
- Design of effective and value-added interventions
- Continuous monitoring of performance parameters and comparing to performance standards and benchmarks published by national, regional, or state regulators, accrediting organizations and internal Molina Healthcare threshold
- Analysis of information and data to identify trends and opportunities, and the appropriateness of care and services
- Oversight and improvement of functions that may be delegated: Claims, UM and/or Credentialing

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- Confirmation of the quality and adequacy of the provider and Health Delivery Organization network through appropriate contracting and credentialing processes

The QIP promotes and fosters accountability of employees, network and affiliated health personnel for the quality and safety of care and services provided to Molina Healthcare Members.

The effectiveness of QIP activities in producing measurable improvements in the care and service provided to members is evaluated by:

- Organizing multi-disciplinary teams, including clinical experts, to analyze service and process improvement opportunities, determine actions for improvement, and evaluate results.
- Tracking the progress of quality activities and goals through appropriate quality committee minutes and reviewing/updating the QI work plan quarterly.
- Revising interventions based on analysis, when indicated.
- Evaluating member satisfaction with their experience of care through the CAHPS® (Consumer Assessment of Healthcare Providers and Systems) survey.
- Reviewing member satisfaction with their experience with behavioral health services through a focused survey and evaluation of behavioral health specific grievances and appeals.
- Conducting provider satisfaction surveys with specific questions about the UM process, such as determining the level of satisfaction with getting a service approved, obtaining a referral and case management.

Molina Healthcare would like to help you to promote the important care activities you have undertaken in your practices. If you would like to have your projects and programs highlighted on the Molina Healthcare website, please contact the Quality Improvement Department at (844) 826-4335.

If you would like more information about our Quality Improvement Program or initiatives and the progress toward meeting quality goals, or would like to request a paper copy of our documents, please call the Quality Improvement Department at (844) 826-4335. You can also visit our website at www.MolinaHealthcare.com to obtain more information.

Standards for Medical Record Documentation

Providing quality care to our members is important; therefore, Molina Healthcare has established standards for medical record documentation to help assure the highest quality of care. Medical record standards promote quality care though communication, coordination and continuity of care, and efficient and effective treatment.

Molina Healthcare's medical record documentation standards include:

- Medical record content
- Medical record organization
- Information filed in medical records
- Ease of retrieving medical records
- Confidential patient information
- Standards and performance goals for participating providers

Below are commonly accepted standards for documentation in medical records and must be included in each medical record:

- History and physicals
- Allergies and adverse reactions
- Problem list
- Medications
- Documentation of clinical findings and evaluation for each visit
- Preventive services/risk screening

For more information, please call the Quality Improvement Department at (844) 826-4335.

Preventive Health Guidelines

Preventive Health Guidelines can be beneficial to the provider and his/her patients. Guidelines are based on scientific evidence, review of the medical literature, or appropriately established authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost considerations.

These guidelines are meant to recommend a standard level of care and do not preclude the delivery of additional preventive services depending on the individual needs of the patient.

To request printed copies of Preventive Health Guidelines, please contact the Quality Improvement Department at (844) 826-4335. You can also view all guidelines at www.MolinaHealthcare.com.

Clinical Practice Guidelines

Clinical practice guidelines are based on scientific evidence, review of the medical literature, or appropriately established authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost considerations. The recommendations for care are suggested as guides for making clinical decisions. Clinicians and their patients must work together to develop individual treatment plans that are tailored to the specific needs and circumstances of each patient.

Molina Healthcare has adopted the following Clinical Practice Guidelines which include, but are not limited to the following:

- Asthma
- Attention Deficit Hyperactivity Disorder
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Heart Failure
- Hypertension
- Obesity
- Opioid Management
- Perinatal Care
- Pregnancy Management
- Sickle Cell Disease
- Substance Abuse Treatment

To request a copy of any guideline, please contact Molina Healthcare's Provider Services Department at (844) 826-4335. You can also view all guidelines at www.MolinaHealthcare.com.

Advance Directives

Helping your patients prepare Advance Directives may not be as hard as you think. Any person 18 years or older can create an Advance Directive. Advance Directives include a living will document and a durable power of attorney document.

A living will is written instruction that explains your patient's wishes regarding health care in the case of a terminal illness or any medical procedures that prolong life. A durable power of attorney names a person to make decisions for your patient if he or she becomes unable to do so.

The following links provide you and your patients with free forms to help create an Advance Directive:

http://www.nlm.nih.gov/medlineplus/advancedirectives.html
http://aging.utah.edu/programs/utah-coa/directives/
www.caringinfo.org

For the living will document, your patient will need two witnesses. For a durable power of attorney document, your patient will need valid notarization.

A patient's Advance Directive must be honored to the fullest extent permitted under law. Providers should discuss Advance Directives and provide appropriate medical advice if the patient desires guidance or assistance, including any objections they may have to a patient directive prior to service whenever possible. In no event

may any provider refuse to treat a patient or otherwise discriminate against a patient because the patient has completed an Advance Directive. Patients have the right to file a complaint if they are dissatisfied with the handling of an Advance Directive and/or if there is a failure to comply with Advance Directive instructions.

It is helpful to have materials available for patients to take and review at their convenience. Be sure to put a copy of the completed form in a prominent section of the medical record. The medical record should also document if a patient chooses not to execute an Advance Directive. Let your patients know that advance care planning is a part of good health care.

Behavioral Health

Primary Care Providers provide outpatient behavioral health services, within the scope of their practice, and are responsible for coordinating members' physical and behavioral health care, including making referrals to Behavioral Health providers when necessary. If you need assistance with the referral process for Behavioral Health services, please contact the UM Department at (844) 826-4335

Verifying NPPES Data

CMS recommends that Providers routinely verify and attest to the accuracy of their NPPES data.
The National Plan and Provider Enumeration System (NPPES) now allows providers to attest to the accuracy of their data. If the data is correct, the provider is able to attest and NPPES will reflect the attestation date. If the information is not correct, the provider is able to request a change to the record and attest to the changed data, resulting in an updated certification date.

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Molina supports the CMS recommendations around NPPES data verification, and encourages our provider network to verify provider data via https://nppes.cms.hhs.gov. Additional information regarding the use of NPPES is available in the Frequently Asked Questions (FAQs) document published at the following link: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.

Coronavirus Information

Molina Healthcare is monitoring COVID-19 developments on a daily basis. Our Corporate Chief Medical Officer (CMO) is working closely with our health plan CMOs across the country to ensure that we are prepared to assist our members and providers.

- There are no changes to our prior authorization process at this time.
- Visits for our members to primary care provider offices or the ER do not require prior authorization.
- Our inpatient prior authorization process remains the same.

We encourage you to monitor the CDC website (https://www.cdc.gov/coronavirus/2019-ncov/index.html) for additional clinical information.

We will update you of any changes as things change with this rapidly developing public health matter.

Provider Portal Corner

We improved the way you can report a data change to us. The new feature allows a Provider or Member to submit demographic corrections directly to Molina.

Online Correction Locations:

Provider Details

Back

Name:	Title:	Ge
DOE, JOHN	DO	Male

NPI:	License ID:	License Type:
1234567890	Not Available	SPECIALIST

Report data change in the Provider Directory
If you are a Molina Member: Submit Here
If you are a Molina Provider: Submit Here
*Medical Doctors are Licensed and Regulated by State Medical board.

POD – Search Details page

Zip: 77080
Mobile Number:
Report an update or inaccuracy in the Provider Directory:
Submit Here
Edit

Provider Portal

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Medicaid (MississippiCAN) & CHIP

Medicaid and CHIP updates

Same Day Services And E&M Codes (Behavioral/Mental Health)

The following instructions apply when filing claims for Same Day Services and E&M Codes:

The CMHC/PMHC fee schedules indicate the following:

E&M Codes (Physician – MD, NP, PA)

- 99201-99205 (For New Patients)
- 99211-99215 (For Established Patients)
- When performing E&M and Psychotherapy on the same day, add-on codes 90833, 90836, 90838 should be billed.

Individual Psychotherapy Codes (LSW, Psychologist, etc.)

- When performing E&M and Master Level Psychotherapy on the same day, add-on codes 90832, 90834, 90837 should be billed with the appropriate modifier, such as XP, XE, etc.

Community Mental Health Centers must use modifiers to distinguish the level of provider performing the services.

Non-Participating Providers

Important Notice to Non-Participating Providers

All Out-of-Network Providers (Physicians, Nurse Practitioners, Facilities, and Ancillary Providers) must obtain a Prior Authorization (PA) prior to rendering services. All Non-Participating Providers require authorization regardless of services or codes.

To join our network, please complete the Contract Request Form found on our website at https://www.molinahealthcare.com/providers/ms/medicaid/forms/Pages/fuf.aspx and follow the instructions given.

After completing, a representative from our Provider Contracting Department will reach out to you regarding the enrollment and credentialing process.

For additional information, email MHMSProviderContracting@Molinahealthcare.com

The Prior Authorization Guide and forms are located on our website at: https://www.molinahealthcare.com/providers/ms/medicaid/forms/Pages/fuf.aspx

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Reimbursement of Non-Participating Providers

Non-Participating Providers are reimbursed at 50% of the current Mississippi Medicaid Fee-For-Service Fee Schedule for covered Non-Emergent services, if accompanied by a valid prior authorization number.

Non-Participating Providers are reimbursed at 100% of the current Mississippi Medicaid Fee-For-Service Fee Schedule for covered Emergency Services. Prior authorization is not required for covered Emergency Services.

Reimbursement will be limited to a period for the treatment of an Emergency Medical Condition, including Medically Necessary services rendered to the Member until such time as he or she may be safely transported to a network Provider service location. From that time forward, the applicable non-participating provider rate will apply.

Members experiencing an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the patient

Claim Denials and Rejection Billing Tips

Rejected vs Denied Claim

Molina processes claims in an accurate and timely manner with minimal disturbances. Claim denials and rejections happen for a variety of reasons.

Rejected Claim – A claim that does not meet basic claims processing requirements.

A few examples of rejected claims include:

- The use of an incorrect claim form
- Required fields are left blank on the claim form
- Required information is printed outside the appropriate fields

Denied Claim – The claim has been reviewed and was determined that it did not meet payment requirements.

A few examples of reasons a claim will deny include:

- An invalid modifier submitted on the claim
- A missing provider address, date of service, or NPI number
- A missing corrected claims indicator or original claim number

Top Billing Errors by Providers:

- Member not found
  - Providers are encouraged to verify the beneficiary's eligibility each visit and prior to submission of each claim. Providers should also periodically review the beneficiary's eligibility information.

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- Missing incomplete/invalid payer claim control number
    - Corrected or Void/Replacement claims must include the correct coding to denote if the claim is Replacement or Corrected along with the ICN/DCN (original claim ID)
- Paper Claim Rejections
    - To avoid a delay in receiving claim payment, ensure the information provided on a paper claim submission is readable, legible, and does not contain white out (correction fluid/tape)
- Invalid/missing Member ID
    - Member ID can be submitted with or without leading zeroes. When leading zeroes are added, it must only contain 5 leading zeros

How to Correct These Errors

Providers can submit corrected claims by the following:

Preferred Method – online via Molina's Provider Portal: **https://provider.MolinaHealthcare.com/provider/login**

Via a Clearinghouse – Molina's Payer ID number is **77010**

Claims Mailing Address
Molina Healthcare of Mississippi, Inc.
PO Box 22618
Long Beach, CA 90801

All reconsiderations must be received within **ninety (90) days** of the date on the Remittance Advice. Molina will respond to your request, in writing, within **thirty (30) calendar days**. Molina offers the following submission options:

- Submit requests directly to Molina Healthcare of Mississippi via the Provider Portal at **provider.molinahealthcare.com**
- Submit requests directly to Molina Healthcare of Mississippi by faxing to **1-844-808-2409**

Claims Submission	Time Frame
Initial Claim	180 Days from the DOS/180 Days from the Date of Discharge
Reconsideration/ Correction/Adjustment	90 Days from the date of denial/EOP
COB	180 Days from the Primary Payer's EOP

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Pre-Pay Audit

Molina Healthcare is committed to continuously improving its overall payment integrity solutions. We began performing additional prepayment claim reviews in June 2019. As a result, the healthcare professional may be asked for medical records and billing documents that support the charges billed.

Molina Healthcare utilizes widely acknowledged national guidelines for billing practices and supports the concept of uniform billing for all payers. These prepayment claims reviews will look for overutilization of services or other practices that directly or indirectly result in unnecessary costs to the healthcare industry. A healthcare professional's order must be present to support all charges, along with clinical documentation to support the diagnosis and services or supplies billed.

Healthcare professionals will receive detailed instruction regarding how to submit requested documentation. Healthcare professionals who do not submit the requested documentation may receive a technical denial, which will result in the claim being denied until all information necessary to adjudicate the claim is received.

If it is determined that a coding and/or payment adjustment is applicable, the healthcare professional will receive the appropriate claim adjudication. Healthcare professionals retain their right to dispute results of reviews.

High Level Evaluation and Management (E/M) Services Evaluation and Review Program

May 1, 2020, Molina Healthcare implemented a program to evaluate and review high level Evaluation and management (E/M) services for high-coding practitioners that appear to have been incorrectly coded, based upon diagnostic information that appears on the claim and peer comparison.

E/M services are visits performed by physicians and non-physician practitioners to assess and manage a patient's health. Both CMS and the Office of Inspector General (OIG) have documented that E/M services are among the most likely services to be incorrectly coded, resulting in improper payments to practitioners.

The OIG has also recommended that payers continue to help to educate practitioners on coding and documentation for E/M services, and to develop programs to review E/M services billed for by high-coding practitioners.

The following are example remittance messages which may be included but not limited to future E&M claims processed:

- Line (X) Service Code '99204, 99205, 99215, 99214' visit level lowered to "99203, 99204. 99213, 99214"
- This claim line was processed using a code that more accurately represents the treatment received.
- The information submitted on the claim does not support the code originally billed. The provider has been reimbursed using the level (insert level) evaluation and management code which more appropriately supports the information submitted on the claim

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- Payer deems the information submitted does not support this level of service.
- Alert: Payment based on an appropriate level of care

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*The below is tailored to the E&M claim selection process, rather than a usual policy edit.

Effective Coding of Evaluation and Management Services

Evaluation and management (E/M) services are visits performed by physicians and non-physician practitioners to assess and manage a patient's health. <<Molina Healthcare>> will be instituting a process to evaluate and review high level E/M services for high-coding practitioners that appear to have been incorrectly coded, based upon diagnostic information that appears on the claim and peer comparison. If you do not agree with a payment determination, you have the right to file an appeal by submitting the portion of the medical record that supports additional reimbursement. Molina Healthcare will review the submitted medical record(s) to assess the intensity of service and complexity of medical decision-making for the E&M services provided.

> Medical Necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level or service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported… CMS Regulations and Guidance (https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r178cp.pdf)

In an ongoing effort to ensure accurate claims processing and payment, Molina Healthcare is taking additional steps to verify the accuracy of payments made to professional providers. Beginning on May 1, 2020, as part of our claims process, Molina Healthcare will be reviewing select claims for evaluation and management (E&M) services to better ensure that payments are aligned with national industry coding standards.

Providers should report E&M services in accordance with the American Medical Association's (AMA's) CPT Manual and the Centers for Medicare and Medicaid Services (CMS') guidelines for billing E&M service codes: Documentation Guidelines for Evaluation and Management. The level of service for E&M service codes is based primarily on the member's medical history, examination and medical decision-making. Counseling, coordination of care, the nature of the presenting problem, and face-to-face time are considered contributing factors.

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