PROVIDER BULLETIN

A bulletin for the Molina Healthcare of Ohio provider networks

Updated: Molina Policy COVID-19 Bypasses

Information for all network providers

Effective Feb. 1, 2024, Molina Healthcare will turn back on edits that were previously paused due to the Public Health Emergency. These will include the following:

- Modifiers for Telehealth: Claim lines that are reported with any COVID-19 related modifiers: 95, CG, CR, CS, G0, GQ, GT. Edits will start firing on inappropriate code-modifier combinations.
- Place of Service (POS) for Telehealth: When claims are reported with any COVID-19 related modifiers 95, CG, CR, CS, G0, GQ, GT and reported in telehealth POS 02, 12, 13. The edit will start firing on inappropriate code-POS combinations.
- New Patient with Telehealth POS: This edit will deny a new patient visit when a previous new patient visit has been reported by a provider of the same specialty within the same group practice within the last three years for POS 02, 12, 13.

Note: Molina will continue to allow Modifiers 93, 95 and GT for Behavioral Health codes.

Prior Authorization (PA) Code Update: 0345U

Information for Medicaid providers

Effective on and after Feb. 1, 2024, the following code will require Prior Authorization (PA) for the Medicaid line of business:

- Genetic Counseling and Testing: 0345U

This update is for notification purposes only and does not determine if the benefit is covered by the member's plan. This code has been added to the Medicaid: Q1 2024 PA Code Changes document on the Forms page on the Provider Website. As a reminder, all other updates noted in the document have an effective date of Jan. 1, 2024.

Reminder: Molina updates the list of codes requiring PA on a quarterly basis. However, changes can be made between quarterly updates. Always use the PA Lookup Tool on our Provider Website to ensure you access the most up-to-date list of codes.

New Functionality in Availity: Submit and Track Appeals

Information for all network providers

Providers now have access to a new process for submitting the following appeals to Molina in the Availity Essentials Portal:

- Authorization Reconsideration (Clinical Claim Dispute).
- Claim Reconsideration (Non-Clinical Claim Dispute).

Providers can:

- Submit the request online for Molina's finalized claims.

New In This Issue – Jan. 2024

Updated In This Issue

In Case You Missed It

Questions and Quick Links

Provider Services – (855) 322-4079
Mon. – Fri. 7 a.m. to 8 p.m. for Medicaid, 8 a.m. to 6 p.m. for MyCare Ohio and 8 a.m. to 5 p.m. for Medicare and Marketplace

- Email: OHProviderRelations@MolinaHealthcare.com
- Provider Website: Molina Healthcare.com/OhioProviders
  - Provider Manual
  - PA Code Updates
  - PA Request Form
  - Provider Bulletin Archive

The Provider Bulletin is a monthly newsletter distributed to all network providers serving beneficiaries of Molina Healthcare of Ohio Medicaid, Medicare, MyCare Ohio and Health Insurance Marketplace health care plans.

- Check the status of the request submitted on Availity.
- View and import requests in Availity that were initiated through outside channels, e.g., fax, verbal.
- Upload supporting documentation for online requests.
- Receive a notification when requests have been finalized and processed by Molina.

Reimplementation of the Coordinated Services Program

Information for Medicaid providers

Effective Jan. 1, 2024, the Ohio Department of Medicaid (ODM) and Gainwell are reimplementing the Coordinated Services Program (CSP). Following this guidance:

- Molina will begin enrolling members into the pharmacy lock-in component of the program only; prescriber-specific lock-in will not be available.
- All members with an active prescriber lock-in as of Jan. 1, 2024 will be disenrolled from this component of the CSP program.
- Any members with existing, active pharmacy lock-in enrollments will continue in the program through the end of their CSP enrollment span.

Providers may view sample Molina member ID cards indicating CSP program participation in the posted Provider Manual. For more information about the program, providers may refer to Ohio Administrative Code (OAC) Rule 5160-20-01.

Ohio Recovery Housing Residences Registration

Information for all network providers

Ohio recovery housing residences are now required to register with Ohio Mental Health & Addiction Services (OhioMHAS). The first deadline was Nov. 3, 2023, but late registrations are still being accepted. Visit apps.mha.ohio.gov/RHR/ for more information and instructions, and contact RecoveryHousing@mha.ohio.gov with questions.

Providers may also contact Ohio Recovery Housing at ohiorecoveryhousing.org for free best practice guidance, outcomes tools and short-term technical assistance and support to recovery housing operators.

OhioRISE Mixed Services Protocol Updated

Information for Medicaid providers

Effective Jan. 1, 2024, the ODM has updated the OhioRISE Mixed Services Protocol. Find the document on ODM's website at managedcare.medicaid.ohio.gov/managed-care/ohiorise/06-community-and-provider-resources. Updates include:

- The addition of diagnosis-related group (DRG) 817 and diagnosis code(s) related to suicide attempts and intentional self-harm to the behavioral health inpatient criteria.
- Updates to the Outpatient Hospital Services criteria due to solely reimbursing outpatient hospital services via the

  - It Matters to Molina Page
  - Provider Portal

Join Our Email Distribution List

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Sign up to receive the Provider Bulletin via email, or to request removal from our fax distribution list by clicking the "Sign up to receive Molina's Provider Bulletin via email here" link on the Provider Bulletin page of our website.

Connect with Us

facebook.com/MolinaHealth
twitter.com/MolinaHealth

Provider Training Sessions

Molina of Ohio is offering the chance to enter a monthly drawing for a prize! To enter, you must join one of our provider trainings and share your name and email address during the training.

It Matters to Molina Forums:

- Molina Provider Website Navigation: Fri., **Jan. 26, 10 to 11 a.m.**
- Medicaid Incident Reporting: Fri. **Feb 23, 10 to 11 a.m.**

General Provider Orientation:

- Mon. **Jan. 8, 11 a.m. to 12 p.m.**
- Mon. **Feb. 5, 1 to 2 p.m.**

Managed Long-Term Services and Support (MLTSS) Orientation:

- Thurs., **Jan. 18, 11 a.m. to 12 p.m.**

NF and Assisted Living Provider Orientation

- Thurs., **Feb. 15, 11 a.m. to 12 p.m.**

Availity Essentials Portal Training:
Register in the Availity Portal. Under "Help & Training," select "Get Trained." Select the "Sessions" tab:

- Tues., Jan. 2, 3 p.m.
- Fri., Jan. 19, 12 p.m.
- Tues., Feb. 13, 2 p.m.
- Contact training@availity.com for Availity Portal training.

transition to Enhanced Ambulatory Patient Group (EAPG) methodology and the sunsetting of the Outpatient Hospital Behavioral Health (OPHBH) reimbursement methodology.
- A section was added to clarify that Services of Autism Spectrum Disorder are not OhioRISE Plan covered services.

Updated: Notice of Changes to the Provider Manuals

Information for all network providers

Molina is in the process of updating our Provider Manuals for 2024.
- Read the Dec. 1 Special Provider Bulletin for significant updates to the MyCare Ohio Manual.
- An article will be forthcoming for significant updates to the Medicaid Provider Manual once final.
- Molina posted the Medicare and Marketplace Provider Manuals to the Provider Website.

Reminder: Molina posts a new comprehensive Provider Manual to our website semi-annually. However, changes can be made to the manual between updates. Always refer to the manual posted on our website under the "Manual" tab instead of printing hard copies. This practice ensures you are accessing the most up-to-date versions.

Medicaid Renewals

Information for Medicaid and MyCare Ohio providers

With a new year upon us, there's new opportunity to assist patients with their annual Medicaid renewal. The annual Medicaid renewal process, which resumed Feb. 1, 2023 enables ODM to confirm that your patients are still Medicaid eligible. If patients do not renew timely or correctly, they are at risk of losing their coverage. The good news is that there are several ways Molina can assist with renewing your patients to prevent unnecessary gaps in coverage:
- File Sharing: Molina receives monthly files from ODM that indicate which members are due for renewal. In turn, Molina can share this information for your Molina patients. This gives you the opportunity to make outbound contact with these patients to remind them of their renewal. It helps prevent patients from learning of their coverage loss when they come for an appointment.
- Lunch and Learns: Molina staff can provide a virtual or in-person session to provide "How to" education on the renewal process.
- Patient Literature: Molina has created patient information to help explain what Medicaid renewal is and how to complete the process. This information is available to our providers for office distribution.
- On-site Assistance: Our team can come onsite and host a Renewal Assistance Day if you have a number of Molina patients due for renewal in the same month. We can help coordinate the event, spread the word and even offer activities and refreshments to encourage participation.

Claim Hold on Marketplace Prospective Payment System

Info for Marketplace providers

Based on scheduled updates for the Outpatient and End-Stage Renal Disease (ESRD) Prospective Payment System (PPS), Molina will be implementing a PPS hold for impacted claims. These claims will remain on hold for dates of service of Jan. 1, 2024 – Feb. 8, 2024.

New ODM Behavioral Health Provider Manual and Rates

Info for Medicaid providers

ODM has posted a new Behavioral Health Provider Manual and Jan. 1, 2024 rates. Visit ODM's website Medicaid.ohio.gov and under Resources for Providers select Behavioral Health for additional provider information and resources.

Q4 Provider Newsletter

Info for all network providers

The Q4 2023 Provider Newsletter is available on the Provider Website on the "Communications" tab. Articles in this edition include:
- Model of Care training is underway.
- 2023-24 flu season.
- NovoLog® (insulin aspart) removed from Molina Medicare formularies for 2024.
- Balance Billing.
- Early and Periodic Screening, Diagnostic and Treatment program.
- Save your HUMIRA® patients money by switching to a HUMIRA® biosimilar.
- Molina's Special Investigation Unit is partnering with you to prevent fraud, waste and abuse.
- Suicide prevention awareness.
- Clinical policy update highlights from third quarter 2023.

PA Request Forms Reminder

Info for all network providers

The preferred method of PA submission is through the Availity portal. If portal submission is not feasible, please access the Forms

Please know that our Molina renewal team is also reaching out to members needing to renew through phone calls, text messages, emails and letters. However, communication coming from their provider and being able to get personal assistance onsite have been found to be effective ways to reach these members.

Reach out to MHOCommunityOutreach@MolinaHealthcare.com to learn more about how Molina can help renew your patients. Please reach out to OHProviderRelations@MolinaHealthcare.com if you are interested in file sharing.

Read the Frequently Asked Questions (FAQs) section on Molina's Medicaid Renewals page to learn more and find instructions on how to access Medicaid Renewal dates for your patients by performing an Eligibility and Benefits inquiry via the Availity Essentials Portal. Primary Care Providers may also access Renewals information on their member rosters in Availity.

CMS Final Rule for CY24: Appointment Wait Time Standards and Additional Professionals Included on the List of Evaluated Specialties

Information for Medicare and MyCare Ohio providers

List of Evaluated Specialties: The Centers for Medicare & Medicaid (CMS) remain committed to emphasizing the critical role access to behavioral health plays in whole-person care. Effective Jan. 1, 2024, in line with CMS' Behavioral Health Strategy and the Administration's strategy to address the national mental health crisis, CMS is strengthening behavioral health network adequacy in Medicare Advantage by adding clinical psychologists and licensed clinical social workers to the list of evaluated specialties.

Wait Time Standards: Effective Jan. 1., 2024, CMS has revised some appointment standards. These updates are reflected in the 2024 Molina MyCare Ohio Provider Manual and will be reflected in the near future within the Molina Medicare Provider Manual.

CMS codifies appointment wait time standards for primary care **and** behavioral health services that are the same as those described in Medicare Managed Care Manual (MMCM) Chapter 4 – Benefits and Beneficiary Protections (1) urgently needed services or emergency - immediately; (2) services that are not emergency or urgently needed but require medical attention - within 1 week; and (3) routine and preventive care - within 30 days. Find Chapter 4 at cms.gov by selecting Regulations & Guidance under the Medicare header, then Manuals, Internet-Only Manuals and 100-16 Medicare Managed Care Manual.

In addition, CMS is requiring most types of Medicare Advantage plans to include behavioral health services in care coordination programs, ensuring that behavioral health care is a core part of person-centered care planning.

page on the Provider Website for the most current PA forms and fax numbers. Note: Using an older version of the form may cause delays in processing.

Evaluation and Management (E&M) Reminder

Info for all network providers

This is a reminder that Molina continues 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.

In an ongoing effort to ensure accurate claims processing and payment, Molina is taking additional steps to verify the accuracy of payments made to professional providers. Providers should report E&M services in accordance with the American Medical Association's (AMA's) CPT Manual and CMS' guidelines for billing E&M service codes.

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.

CMS Final Rule for CY24: Behavioral Health Changes

Information for behavioral health providers

The Consolidated Appropriations Act, 2023 (CAA, 2023) has established a new Medicare benefit category for Marriage and family therapist (MFT) and Mental Health Counselor (MHC) services furnished by and directly billed by MFTs and MHCs. Payment for MFT and MHC services under Part B of the Medicare program will begin Jan. 1, 2024. These provider specialties are not Medicare covered providers today and not allowed to bill for Medicare services directly.

Marriage and Family Therapists & Mental Health Counselors:

- MFT taxonomy code 106H00000X
- MHC taxonomy code 101YM0800X

Enroll in Medicare now:

- Starting for dates of service Jan. 1, 2024, MFTs and MHCs can bill independently for services furnished for the diagnosis and treatment of mental illnesses.
- Find out how to become a Medicare provider, at cms.gov by selecting Enrollment & renewal under the Medicare header, then Providers & suppliers and taking the listed steps to enroll.
- Once you enroll with CMS, submit a Provider Information Form (PIF) to Molina identifying your new Medicare identification number in Section N.

New Medicare Benefits:

Psychotherapy for Crisis: Medicare pays for psychotherapy for crisis (currently billed using Current Procedural Terminology (CPT) codes 90839 and 90840).

Effective Jan. 1, 2024, CMS established new HCPCS codes for psychotherapy for crisis services (HCPCS codes G0017 and G0018) that are furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting). Additional information can be viewed by accessing the Psychotherapy for Crisis page at cms.gov by selecting Payment under the Medicare header, then Fee Schedule and Physician Fee Schedule.

Intensive Outpatient Programming (IOP): IOP is a new benefit that will be a standard Medicare offering effective Jan. 1, 2024.

An IOP is a distinct and organized outpatient program of psychiatric services provided for individuals who have an acute mental illness or substance use disorder, consisting of a specified group of behavioral health services paid on a per diem basis under the Outpatient Prospective Payment System (OPPS) or other applicable payment system when furnished in hospital outpatient departments, Community Mental Health Centers (CMHC), Federally Qualified Health Centers (FQHC), and Rural Health Clinic (RHC).

Update: New Century is Now Evolent

Info for Medicaid and Marketplace providers

Effective Q1 2024, New Century Health is changing their name to Evolent.

Reminder: ODM Source of Truth for Provider Data

Info for Medicaid and MyCare Ohio providers

On Oct. 20, 2023, ODM issued a "News for Ohio Medicaid Providers" communication with an article entitled, IMPORTANT: ODM will not deny claims associated with data integration to ensure readiness. Find it at managedcare.medicaid.ohio.gov/news/news-for-providers.

Molina is following this ODM guidance. Please review the ODM communication and take any necessary actions to update your records in the PNM system as soon as possible.

Reminder: Review Your Molina Medicaid Member's Renewal Date in Availity

Info for Medicaid providers

Perform individual Eligibility verifications in Availity. Results will show a redetermination date for any member upcoming in the next 60 days in scenarios where the member needs to take action.

- Log in to Availity.
- Choose to do an Eligibility and Benefits Inquiry.
- Enter the patient's information and click submit: Enter in either Molina Member ID or state ID along with Date of Birth (DOB) and select the state of residence. If you do not have the Member ID, enter the First Name, Last Name and DOB and select the state of residence.
- If the member has a renewal date coming within 60 days and needs to take action, a message

Important Reference Links:

- CMS Press Release: cms.gov/files/document/marriage-and-family-therapists-and-mental-health-counselors-faq-09052023.pdf
- CMS Behavioral Health FAQs: cms.gov/files/document/marriage-and-family-therapists-and-mental-health-counselors-faq-09052023.pdf
- Fact sheet on Final Rule: cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f

ODM Rate Updates for 2024

Information for Medicaid and MyCare Ohio providers

The ODM fee schedule updates will be in Molina's system by Jan. 1, 2024, for dates of service Jan. 1, 2024 and after for the following:

- Appendix DD: OAC rule 5160-1-60
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS): OAC rule 5160-10-01
- Wheelchairs and Related Parts and Services: Appendix to OAC rule 5160-10-01, related to OAC rule 5160-10-16
- Oxygen and Related Items and Services: Appendix to OAC rule 5160-10-01, related to rule 5160-10-13
- Transportation: OAC rule 5160-15-28
- Community Behavioral Health: OAC rule 5160-27-03

The rate updates for the following will be in Molina's system by the dates noted below. All impacted claims will be reprocessed for dates of service on and after Jan. 1, 2024:

- Anesthesia Services by Jan. 4, 2024
- Dialysis by Jan. 4, 2024
- Private Duty Nursing by Jan. 11, 2024
- Home Health by Jan. 11, 2024
- Waiver by Jan. 11, 2024
- Nursing Facilities by Jan. 15, 2024
- Clinical Laboratory Services by Jan. 16, 2024
- Ambulatory Surgical Center (ASC) by Jan. 17, 2024

Diabetes Benefits Update in 2024

Information for Medicaid providers

Molina and the Ohio Medicaid Managed Care Organizations (MCOs) are working collaboratively to make diabetes management easier for providers and their patients. Diabetes education and support and the use of continuous glucose monitors (CGMs) have proven to be effective in diabetes care management.

To facilitate increased utilization of these important tools, Molina and the other MCOs will pay an enhanced reimbursement rate to providers rendering Diabetes Self-Management Education (DSME) and billing the appropriate codes: G0108 and G0109. In addition, PA is **not** required for members who receive a covered CGM device through durable medical equipment (DME) providers or through

will display with their renewal date.
- If the member does not have a renewal date coming within 60 days and/or does not need to take action, a message will not appear.

As a reminder, ODM resumed the Medicaid renewals (also referred to as "Medicaid redeterminations") process on Feb. 1, 2023. The first disenrollments for non-renewal or loss of eligibility occurred on April 30, 2023, with a May 1, 2023, effective date.

Please visit the FAQs on Molina's website Medicaid Renewals, to learn more. Primary Care Providers may also access Renewals information on their member rosters located in Availity.

Reminder: New Medicare PA Guide, Forms

Info for Medicare and MyCare Ohio Providers

Molina posted updated Medicare PA Guide and PA Forms to the Medicare Provider Website. Providers should include all necessary information when submitting authorization requests to reduce delays and the need for additional information. Molina uses CMS, state, MCG, and Molina policies.

Find the PA Guide and Forms on the Medicare Provider Website under Prior Authorization Forms and on the MyCare Ohio Provider Website under the "Forms" tab. Authorization requests should be submitted via the provider portal at provider.MolinaHealthcare.com.

Reminder: Medicaid Enrollment Requirements

Info for Medicaid providers

As a reminder, any provider, group ordering or referring who is not enrolled and noted as "active" in the ODM Provider Network Management (PNM) system will receive denials for claims

their pharmacy. Providers must use Healthcare Common Procedure Coding System (HCPCS) codes A4239 and E2103 for CGMs provided through DME.

For additional information regarding these updates, including who to contact at each MCO for questions, see the quick reference guide on our Provider Website, on the Quick Reference Guides & FAQs page, under the Manual tab.

ePRAF: Technical Assistance Intervention Package

Information for Medicaid providers

A complete Pregnancy Risk Assessment Form (PRAF) helps members receive the best support for a healthy pregnancy.

Assessment of risk and access to needed services directly impacts pregnancy related outcomes including maternal and infant mortality. The electronic PRAF (ePRAF) can act as the catalyst to partnership and collaboration between the provider and MCO to best address each patient's needs and risks.

Providers can face unique barriers when it comes to ePRAF submission. The MCOs have created a Technical Assistance Intervention Package that addresses these individual challenges, allowing providers to choose interventions that best meet their need for assistance.

The Technical Assistance Package is a collection of resources, tools and reporting that is designed to assist providers in delivering high-quality pregnancy related care to their patients.

All MCOs will be extending these offerings to engaged providers in 2024 to ensure sustainability of this intervention package.

- "Engaged" is defined as those providers who agree to be included in the program and work with the MCOs on process improvement regarding their submission of ePRAFs.

Providers wishing to improve ePRAF submission outcomes should contact their Molina Provider Relations Team for more information.

PRAF GAP Reporting: Each MCO will send a report to the provider of their attributed, pregnant patients who do not have a submitted PRAF.

Gap reports of pregnant patients can effectively support obstetrical providers in increasing ePRAF submissions. The MCOs can help monitor provider "back logs" as well as ensure providers have a stable process in place to sustain future timely submissions.

Billing Review: Financial opportunity review with provider based on claims data.

Review and reporting assists providers to identify process improvement and stabilization regarding billing practices. Correct coding and timely submission on ePRAF claims equate to increased revenue generation for providers.

submitted to Molina. Claim denials will continue until the provider's Medicaid enrollment is noted as an "active" status.

Note: Providers who update their records after claims begin rejecting will need to submit corrected claims once the records are updated.

Visit medicaid.ohio.gov for additional information. Note that Medicaid enrollment is required by the CFR rule 42 CFR 438.602.

Reminder: EOP Refund and Forwarding Balance Reporting Enhancement

Info for all network providers

As a reminder, Molina made enhancements to the reporting of refunds received that are displayed on the Explanation of Payment (EOP) and 835 files, as well as Forwarding Balances.

Refund amounts were previously combined as a bulk total for the payment with a reference ID of the payment check history ID (CHKHST ID) on an EOP and 835. These sections will be updated to utilize a reference ID of the claim itself, allowing for more precise reporting of these transactions. Note: The setup of using WO/72 code types will remain. Updates include:

- EOP: Reference ID on the EOP adjustment section will reflect the claim ID for the transactions related to each refund posting and no longer use the check history ID.
- Provider Level Balance (PLB) segment on the 835: Items labeled as Provider Return/Refund credit will be reflected on the 835 as adjustment code type 72 with a reference ID of the claim ID for each refund. Items labeled as Overpayment Recovery will be reflected on the 835 as adjustment code type WO with a reference ID of the claim ID for each refund. This is Molina's method of recording refunds

ePRAF: Quality Enhancer Incentive Program

Information for Medicaid providers

Why ePRAF is Important – Ensuring Prompt Care

- Every pregnant member with Medicaid coverage should be linked to needed services on their very first prenatal visit. Submission of the ePRAF in the first trimester impacts and improves health outcomes of both member and baby. An ePRAF submission ensures: Medicaid coverage for member and baby without disruption through the immediate post-partum period of 12 months post-delivery. **This is increasingly important given the current redetermination (renewal) process**.
- Serves as pregnancy notification to MCOs and initiation of timely health care and connection to added resources and care coordination.

Incentive Program Details: To assist providers with the prioritization of ePRAF submissions, the Quality Enhancer Incentive Program provides increased payments to eligible providers who submit the ePRAF via the NurtureOhio website on behalf of their pregnant patients.

- The program incentive is an additional **$110** payment on top of the ODM Fee Schedule amount for ePRAF submission; bringing the total for a **first time** ePRAF submission to **$200**.
- Incentive dollars will only be issued for the **first** ePRAF submitted for each pregnant Ohio Medicaid patient. Additional ePRAF submissions due to change in pregnancy related risk or needs, will be paid at the allowable ODM Fee Schedule amount of $90.
- To ensure sustainability of this program, all MCOs will be extending this incentive to engaged providers in 2024. Find additional information in the Technical Assistance Intervention Package ePRAF article above.

Payment for Completing the ePRAF: After completing the ePRAF, submit a claim based on the guidelines below:

- Code + Modifier: H100 + 33.
- Description: ePRAF Submission.
- Fee Schedule Amount and Incentive Amount: $90 + $110 = $200.
- No additional coding is needed for the Quality Enhancer incentive to be paid. Providers who are engaged in the program will have incentive dollars as described above; paid as a lump sum distribution after Dec. 31, 2024 (allowing for a 90-day data tabulation period).
- FQHC/RHC Billing Guidance – ePRAF submission claims should be reported separately as covered non-Prospective Payment System (PPS) services under the "clinic" provider number (provider type 50) of the FQHC/RHC. Billing is Fee-for-Service and is additional to any PPS visit payment.

received and will result in a net total of $0.00 on your payment.

Reminder: HEDIS Measure: Transitions of Care

Info for all network providers

The transition from an inpatient hospital setting back to home can be a vulnerable period for a patient as well as challenging for their provider. It can often result in poor coordination of care, lapses in communication among the inpatient and outpatient providers, intentional and unintentional medication changes, incomplete diagnostic workups, and insufficient understanding of diagnoses and follow-up needs. The Transitions of Care HEDIS Measure assesses four key points for patients 18 years of age and older following a discharge from an inpatient facility. These include:

- Notification of Inpatient Admission – Documentation of receipt of notification and inpatient admission on the day of admission through two days after the admission.
- Receipt of Discharge Information – Documentation of receipt of discharge information on the day of discharge through two days after the admission.
- Patient Engagement After Inpatient Discharge – Documentation of patient engagement, such as office, telehealth, or home visits, provided within 30 days after discharge.
- Medication Reconciliation Post-Discharge – Documentation of medication reconciliation on the date of discharge through 30 days after discharge.

Find additional information in the HEDIS Tip Sheet: Transitions of Care (TRC) document on our Provider Website, on the It Matters to Molina page, under Tools and Resources.

Submitting the PRAF 2.0 using NurtureOhio is Easy:

- Users will need to establish an OH|ID account to access the Provider Network Management System (PNM).
- With PNM access, next step will be to register within the NurtureOhio site nurtureohio.com.
- Instructions for completion and submission of the ePRAF can be found at: medicaid.ohio.gov/Provider/PRAF.
- If you need assistance, please email ODM at MomsandBabies@Medicaid.ohio.gov.

Reminder: Retirement of Episode-Based Payment Model Reports

Information for all network providers

Effective Jan. 1, 2024, ODM will retire the Episode-Based Payment Model as an Alternative Payment Model (APM).

ODM will rescind OAC 5160-19-4 and remove language detailing episodes-based payments from the Ohio Medicaid State Plan.

For additional information, read the ODM August 2023 Episodes of Care Program Retirement letter by visiting medicaid.ohio.gov, and under Resources for Providers, select the > next to Program & Initiatives, then Value-Based Payment, Episode-based Payments and Episodes of Care Announcements.

Reminder: Optum Prepayment Claim Audit

Information for all network providers

Molina, in partnership with Optum, performs prepayment medical record audits. This process utilizes billing practice guidelines to support uniform billing and coding for all payers. The prepayment review of claims and medical records ensures claims are billed accurately and coded correctly in accordance with Current Procedural Terminology (CPT), state and federal policies. The concepts utilized for the prepayment audit align with correct coding practices and incorporate a review of medical records to validate the submitted medical coding of services. This is not a medical necessity review.

Effective Jan. 1, 2024, Optum, on behalf of Molina, will expand this process to include auditing of the following services. Medical records may be requested prior to payment.

- On Facility outpatient claims with revenue codes for trauma response (0681 – 0689), when claims history does not indicate an ambulance service between HCPHC 'A0021' and 'A0999' exists for the same member on the same date of service.
- On professional claims billing for CPT 93229 – Mobile Outpatient Cardiac Telemetry Monitoring (MOCTM) - Technical Component to ensure the stringent documentation guidelines for reporting this code are met.
- On professional claims that are submitted with a paid drug administration but the drug or biologic, on the same claim or corresponding claim, was denied. As such, the drug administration should also be denied.

Reminder: Molina CES Edit 9534 – Modifier GZ

Info for Medicaid providers

Effective Jan. 1, 2024, based on guidance from CMS, Edit 9534 will deny Medicaid Facility Outpatient claims when the presence of modifier GZ indicates this is not eligible for payment.

Find additional information in Chapter 1 – General Billing Requirements of the 100-04 Medicare Claims Processing Manual, located at cms.gov under "Medicare" by selecting "Regulations & guidance" then "Manuals" and "Internet-Only Manual (IOMs)."

Reminder: New Molina CES Edit 9056 – Unspecified Code

Info for Medicaid providers

Effective Jan. 1, 2024, based on guidance from the Centers for Medicare and Medicaid Services (CMS), Edit 9056 will deny Medicaid Inpatient claims when unspecified diagnosis codes are reported as a principal or secondary diagnosis based on the Medicare Code Editor (MCE).

Find additional information in the CMS Change Request 12471 document, located at cms.gov under "Medicare," select "Regulations & guidance" then "Transmittals," and in "2021 Transmittals," look for CR# 12471 or Transmittal# R11059CP.

Reminder: Claim Status Secure Messaging: Availity Essentials Portal

Info for all network providers

Providers can now submit secure messages directly to Molina from the claim status screen via Availity's messaging application.

- Go to claims & payment, then select claims status.
- Providers will need the claim status and messaging application to access the function.

- On professional and outpatient claims billed for arterial selective catheter placement of the third order for placement above the diaphragm (36217) and below the diaphragm (36247) when claim details suggest that a first or second order arterial branch above the diaphragm (36215 and 36216 respectively) or below the diaphragm (36245 and 36246 respectively) was more likely the location of the procedure. Records will be reviewed to determine if the coding guidelines required to bill arterial selective catheter placement of the third order are met.
- On professional claims billed for distal Claviculectomy procedures. Claviculectomy is defined as the partial removal of the clavicle, also known as the collarbone. The focus of the procedure is the distal (outer part) of the clavicle. It is suspected that such instances indicate potential misuse of CPT 23120 & 29824 as those procedures are generally inclusive to the primary procedure.

Reminder: Dental Credentialing Update

Information for Medicare dental providers

On Jan. 1, 2024, the administration of dental services for Molina of Ohio Medicare Choice Care (HMO) will transition from Delta Dental to Molina Dental Services and the SKYGEN Dental Hub.

Currently, ODM credentials providers for Medicaid and MyCare Ohio, but not for Medicare. As a Molina Medicare provider, Molina is required to credential our network of providers.

To credential with us, please complete the following steps:

- Complete Section A and Section N of the Provider Information Form (PIF) and include your Council for Affordable Quality Healthcare (CAQH) ProView ID # to credential the provider by returning the completed form via email to MDVSPIM@MolinaHealthcare.com or fax to (844) 891-2865.
- CAQH must be re-attested within the last 4 months by visiting proview.caqh.org.
- Groups may attach a roster to their PIF with the provider name, NPI and CAQH #.
- Indicate "global" authorization, which allows access to your data profile to all healthcare organizations.
- Upload copies of your current DEA license and malpractice insurance copy directly to CAQH.

If you have questions regarding the transition, please reach out to Molina Dental Provider Services at MDVSProviderServices@MolinaHealthcare.com or by phone at (844) 862-4564.

Tips:

- Initiate a message via the "message this payer" option.
- Allow up to five business days for a response.
- Access the messaging queue from the top right corner of the Availity home page.
- Conversations are displayed as cards. The color of the card indicates the status.
- If a message is missing from your queue, clear your filter options. All users have sorting and filtering options.

Message directly with Molina on:

- Basic inquiries or questions.
- Claim Reconsiderations (Not a formal appeal).
- Enrollment denials.
- Incorrect COB denials.

Claims Secure Messaging is not ideal for timely filing denials, formal appeals/disputes, EOPs, appeals status, Eligibility and Benefit (E&B) verifications (use E&B Secure messaging), overpayments, claims corrections (including COB denials) and denied PA.

Fighting Fraud, Waste and Abuse

Do you have suspicions of member or provider fraud? The Molina 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.