Meeting Agenda

- Introductions
- Credentialing Update
- Billing Instructions
- Claims Adjudication
- Reimbursement Methodology
- MCO Website
- Provider Portal
- Provider Claims Disputes
- Discharge Planning
- Utilization Review
- Issue Escalation

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Introductions

**Matt Wolf, VP Network Mgt. Operations:** Matt’s areas of expertise include claims operations, delegation oversight, network management and servicing. Matt serves as chair of the Illinois Association of Medicaid Health Plans (IAMHP) Operations Committee and has worked in Illinois Medicaid since 2014.

**Lori Lomahan, Director Healthcare Services:** Lori is responsible for oversight of care coordination activities out of our Oak Brook office. As a Licensed Clinical Social Worker (LCSW), Lori has experience working in Illinois Medicaid managed care for the last 5 years.
Credentialing Update

• Credentialing for the HealthChoice Illinois program is no longer required from Managed Care Organizations (MCOs) and providers actively registered with IMPACT are considered credentialed to participate in the HealthChoice Illinois program

• Credentialing is still a requirement for providers under the Medicare-Medicare Program (MMP), Market Place, Medicare Advantage, and commercial products that MCOs may be participating in
  – Providers will be required to submit all relevant credentialing applications if they’re participating under any of these programs

• Providers will still be required to submit all required information to adequately address MCO requirements for provider directories, which includes but is not limited to:
  – Hours of operation
  – Cultural competency training attestations
  – Hospital affiliation
  – W9
Billing Instructions

• Molina Healthcare adheres to the Medicaid fee-for-service (FFS) billing requirements for inpatient and outpatient services

• Molina requires that hospital outpatient services submitted on a UB-04 (837I) include one of the following:
  – Ambulatory Procedure Listing (APL) procedure code OR
  – Emergency room (ED) revenue code OR
  – Observation (OBV) revenue code

• Failure to have an APL code, Healthcare Common Procedure Coding System (HCPCS), ED revenue code, and/or OBV revenue code on the 837I will result in rejection of the entire claim

• Any updates to billing guidelines will be communicated via the Molina Healthcare Communications News & Updates site, updated in our provider manual, published in provider bulletins, and covered during our provider education sessions

• Be aware of difference in form types for MMP and Medicaid services and difference in guidelines between the two programs
Claims Adjudication

- Molina Healthcare processes more than 90% of claims received within 30 calendar days, and 99% of claims are processed within 90 days following receipt.
- These standards must be met in order for Molina Healthcare to remain compliant with State requirements and ensure Providers are paid in a timely manner.
- Claims Submission Options
  - Submit claims directly to Molina Healthcare of Illinois (CMS 1500 or UB04 paper/837p or 837i electronic/Web Portal)
  - Electronically filed claims must use **Payor ID number 20934**
  - Mail paper claims to:
    Molina Healthcare of Illinois
    P.O. Box 540, Long Beach Ca 90801
  - Clearinghouse (Emdeon)
    • Emdeon is an outside vendor that is used by Molina Healthcare of Illinois
    • Providers can use any clearinghouse of their choosing (fees may apply)
- Known system issues will be communicated via our provider communications website
Reimbursement Methodology

• All outpatient hospital and ASTC claims are grouped and priced through 3M™ Enhanced Ambulatory Patient Grouping System (EAPG) software.

• Molina Healthcare of Illinois utilizes the Optum® web-based application Web.Strat™ for our EAPG pricing policies.

• Molina Healthcare of Illinois works directly with staff Optum® on all system updates upon notice from HFS of any changes in billing requirements.

• Molina implements a testing process of claims once Optum confirms configuration updates have been made and changes will not be moved into production until Molina issues approval.
Provider Portal

The Web Portal is a secure site that offers Molina Healthcare providers convenient access, 24 hours a day, seven (7) days a week, to the following functions:

- **Member Eligibility and Benefit Information:** Users can verify member eligibility as well as view benefits, covered services, and members’ health records.
- **Member Roster:** Users can view a list of assigned membership for PCP(s) within the user's provider panel.
- **Service Requests/Authorizations:** Users can create, submit, and review Prior Authorization requests.
- **HEDIS® Profile:** Users can view their HEDIS® scores and search for members with needed services.
- **Claims:** Users can submit, correct, and void claims. Users can also check claim status, and view claims reports for all submitted claims.

You can register for and access the Web Portal by going to: [https://Provider.MolinaHealthcare.com](https://Provider.MolinaHealthcare.com)
Provider Portal

HEDIS Provider Profile

• View your HEDIS® scores and compare performance against peers and national benchmarks.
• Search/filter for members who need HEDIS® services
• Submit HEDIS® chart documentation online for completed service, so we can update our system.
• Retrieve/print a list of members who need HEDIS® services completed.

Submit HEDIS® Chart Documentation for Completed Services

• To view documents for a specific member, first select a member by checking the box in the first column.
  – Select View Documents at the bottom of the screen.
  – A pop up will display with a list of documents submitted for this member.
• If a member has completed a service that is being shown as Needed, you can submit relevant medical record documentation (e.g., progress note, immunization record, lab report, etc.) by choosing the member and selecting Upload Documents.
• The attachment tool will appear allowing you to upload multiple files. Any file format can be attached as long as the total size is under 2GB.
• Once the documentation has been uploaded, the HEDIS® team will review the chart. If it meets HEDIS® criteria, we will update our records within 60 days of receipt of documentation.
Provider Portal

The **Claims** module has six (6) functionalities:
- Claims Status Inquiry
- Create Professional Claims
- Create Institutional Claims
- Open Saved Claims
- Create/Manage Claims Template
- Export Claims Report to Excel

Please visit our [Provider Portal Quick Reference Guide FAQ](#) for more information about the Molina Provider Portal
Provider Claims Disputes

- Providers seeking a redetermination of a claim previously adjudicated must request such action within 90 days of Molina Healthcare Healthcare’s original remittance advice date. Additionally, the item(s) being resubmitted should be clearly marked as a redetermination and must include the following:
  - The item(s) being resubmitted should be clearly marked as a Claim Dispute/Adjustment.
  - Payment adjustment requests must be fully explained.
  - The previous claim and remittance advice, any other documentation to support the adjustment and a copy of the referral/authorization form (if applicable) must accompany the adjustment request.
  - The claim number clearly marked on all supporting documents

- These requests shall be classified as a Claims Disputes/Adjustment and be sent to the following address:
  Molina Healthcare of Illinois
  Attention: Claims Disputes / Adjustments
  1520 Kensington Rd., Suite 212
  Oak Brook, IL 60523
Provider Claims Disputes

- **Provider Claim Inquiry** – Defined as checking the status on if a claim has been paid or denied. For claims paid an inquiry can be made to determine why a certain amount was paid or why a claim was denied. Claims inquiry can be checked via the Molina Provider Portal or by calling our Customer Service line at (855) 687-7861.

- **Provider Claims Disputes** – Defined as a decision has been made on a claim that the provider does not agree with. A disagreement can be on the amount paid or why a claim was denied. Claims disputes should be completed via the Claims Dispute Request Form and submitted via fax to (855) 502-4962.
  
  – Molina is currently updating our Provider Portal capabilities to allow for claims disputes to be submitted via the portal, which would generate an automatic reply indicating we’ve received your dispute and are currently working towards resolution with a notification once a determination has been made.

- **Appeals** – Defined as a request for review of a decision made by Molina with respect to an adverse benefit determination. Most common appeals are authorization denials requesting services to be performed.
Discharge Planning

- Process for transferring of member from out of network to in network facilities
  - The primary reason for transfer is when a hospital requests the transfer; otherwise Molina avoids this unless absolutely necessary (emergent situation)
  - When a hospital requests a transfer, the treating physician gets approval from the receiving hospital prior to the transfer

- Process for assuring timely post acute care placement
  - Communication between MCO and Hospital is imperative
  - Hospital and MCO must anticipate member’s discharge needs and begin acting on referrals, prior auth requests as soon as possible (authorization TAT, clinicals required)
  - For Home Health needs, there is no auth needed for the eval + 6 visit
  - Some members are truly hard to place – hx of violence or offenses, behaviors
  - Local Molina Transition of Care coaches are involved in most discharge plans
    - (assigned to high volume hospitals, go onsite, primary point of contact for hospital staff and member)
Utilization Review

• Molina’s concurrent review process
  - Adhere to strict turn around times
    • Notifications by contracted providers required within 1 business day of admission with clinicals (MCO must respond within 24 hours of receipt)
    • Conduct reviews using evidence based criteria (MCG)
    • Second level review as indicated

• Submitting medical records for review
  - Supporting clinical information required for UM process
  - Faxed requests for necessary clinical
  - Administrative denial when clinical not received

• Methodology for classification of inpatient vs observation
  - Conditions that often response within 48 hours
  - Action plan equates evaluation or monitoring of symptoms
  - Need for testing or re-testing
  - Does not require authorization
Utilization Review

• Review criteria
  - 2018 MCG criteria for inpatient review.
  - Widely used by 8 out of 10 largest health plans/1600+ hospitals nationwide
  - Addresses more than 300 conditions
  - Guidelines for problem-oriented/complex patient situations

• Peer to Peer process (MD to MD)
  - Offer peer to peer before second level review
  - Medicaid: reconsideration available
  - Medicare: once denial rendered, official appeal process available
Issue Escalation

• For issues that cannot be resolved through our customer service line, provider service representative, contract management team, or provider dispute resolution team please escalate your concerns to the attention of:
  – Tracy Pacheco, Director of Provider Services
    • Tracy.Pacheco@molinahealthcare.com
    • 630-203-3949
  – Matt Wolf, VP of Network Mgt. & Operations
    • Matthew.Wolf@MolinaHealthCare.Com
    • 630-203-3983
MCO Website

- Provider Manual
- Provider Online Directories
- Web Portal
- Frequently Used Forms
- Preventive & Clinical Care Guidelines
- Prior Authorization Information
- Advanced Directives
- Model of Care training
- Pharmacy information
- HIPAA

- Fraud, Waste & Abuse Information
- Communications & Newsletters
- Member Rights & Responsibilities
- Contact Information

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Appendix
A successful Member Eligibility Search will provide access to Enrollment Status, HEDIS Alerts, and Enrollment Restrictions. On the details page of member eligibility, users can view the member’s demographic information as well as any additional member information, enrollment information, primary care provider information, and IPA group information, and history. From the Member Eligibility Details page, users can also print details, submit claims, check claim status, and submit service requests/authorizations.
Important Links

• Molina Healthcare of Illinois Provider Home Page
• Provider Portal
• Provider Manual
• EDI ERA/EFT Information
• Important Forms
• Molina Contracting Forms
• Prior Authorization Codification List
• How to Complete a Prior Authorizations
• Claims Dispute Request Form
• Guide to Provider Changes
• News & Updates