MOLINA HEALTHCARE

PROVIDER BULLETIN

A bulletin for the Molina Healthcare of Ohio provider networks

Changes for Non-Contracted Behavioral Health Providers

Information for Medicaid and MyCare Ohio network providers

Effective Oct. 1, 2020, non-contracted (out-of-network) Community Behavioral Health Center (CBHC) providers who deliver services to Molina members will be required to submit a Prior Authorization (PA) for all services per Molina's standard policies. Failure of a non-contracted provider to obtain prior authorization will result in claim denials for those services.

This change is based on the July 1, 2020 update by the Ohio Department of Medicaid (ODM) to the transition of care language in Appendix C of the Managed Care Plan (MCP) Provider Agreement, under "31. Transition of Care Requirements for Managed Care Members Receiving Behavioral Health Services."

Providers who wish to join the Molina network should reach out to MHOBHProviderTeam@molinahealthcare.com.

For additional information visit https://bh.medicaid.ohio.gov and select "MITS BITS & Newsletters" then "August 11, 2020 – Managed Care Changes Coming – October 2020."

Top Denials

Information for all network providers

Molina has identified the top denial reasons that are responsible for the highest volume of denials on Behavioral Health (BH) claims.

1. **Coordination of Benefits (COB) when provider did not submit primary Explanation of Benefits (EOB):** Primary insurance information can be populated on electronic claims. Consistent with Health Insurance Portability and Accountability Act (HIPAA) 5010 billing guidelines, providers are required to report the following COB information:
   - COB carrier name
   - Carrier Identification (ID)
   - Paid amounts
   - Disallowed amount using respective Claims Adjustment Reason Code (CARCs)/Remittance Advice Remark Code (RARC)
   - Paid date

   NOTE: When submitting through the Molina Provider Portal, providers will need to attach a copy of the primary carrier's EOB. For additional information visit our website, and read the "Coordination of Benefits" section of the Provider Manual, located under the "Manual" tab.
2. **Lacking appropriate modifier:** It is extremely important to accurately report modifiers as they are used to price services and adjudicate claims. Providers should reference the Behavioral Health Provider Manual on the ODM BH website at https://bh.medicaid.ohio.gov/manuals for appropriate modifiers.
3. **Ordering provider not present on claim:** View the "Supervisor, Rendering, Ordering Fields" spreadsheet on the ODM BH website, under the "Billing and IT Resources" header.
4. **Billing SUD PT 95 services under Mental Health PT 84 National Provider Identifier (NPI) or vice versa:** View the Behavioral Health Provider Manual on the ODM BH website for services that are specific to Mental Health (MH) or Substance Use Disorder (SUD).

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Questions?

Provider Services – (855) 322-4079
8 a.m. to 5 p.m., Monday to Friday
(MyCare Ohio available until 6 p.m.)

Email us at BHProviderServices@MolinaHealthcare.com

Visit our website at MolinaHealthcare.com/OhioProviders

Visit the ODM BH website at https://bh.medicaid.ohio.gov/ manuals

How to Join WebEx

To join WebEx, call (404) 397-1516 and follow the instructions. To view sessions, log into WebEx.com, click on "Join" and follow the instructions. Meetings passwords are case sensitive. For trouble connecting to a Molina training, email Molina at OHProviderRelations@MolinaHealthcare.com and we'll assist you with getting connected immediately.

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Behavioral Health Provider Manual

On July 17, 2020, the Behavioral Health (BH) Provider Manual was updated by ODM and OhioMHAS. Visit the ODM BH website to view the updated manual.

5. **Failure to submit corrected claims:** Corrected Claims are considered new claims for processing purposes. Corrected Claims must be submitted electronically with the appropriate fields on the 837I or 837P completed. Reminders for the Corrected Claims process:
   - Submit electronically or on the Provider Portal
   - Include all elements that need correction, and all originally submitted elements
   - Do not submit only codes edited by Molina
   - Do not submit via the Claim Reconsideration process
   - Do not submit paper corrected claims
   - Include the original Molina Claim ID Number

   NOTE: Corrected Claims must be received by Molina no later than the filing limitation stated in the Provider Contract or within 365 days of the original remittance advice. For additional information visit our website, and read the "Corrected Claims" section of the Provider Manual, located under the "Manual" tab.
6. **Failure to submit original claim within 365 days timely filing limit:** Providers should promptly submit claims to Molina for covered services rendered to members. Claims for covered services rendered to members must be received by Molina no later than the timely filing limit. Claims received after the timely filing limit will be denied. For additional information visit our website, and read the "Timely Claim Filing" section of the Provider Manual, located under the "Manual" tab.
7. **Claims Denial Rollup for Same Day Services when the same service(s) are provided to the same patient on the same day; claims need to be "rolled up" and submitted as one detail line even if the services are not provided continuously on the same day:** When the same service(s) are provided to the same patient on the same day, claims need to be "rolled up" and submitted as one detail line even if the services are not provide continuously on the same day. For additional information view the "Claims Detail Rollup for Same Day Services" section of the BH Provider Manual on the ODM BH website.
8. **Invalid diagnosis:** View the "2019 ICD-10 DX Code Groups BH Redesign" spreadsheet on the ODM BH website, under the "Billing and IT Resources" header. If a claim is received by Molina for services without an allowable diagnosis code on the list, the claim will deny. Please make sure your billing department and clinicians are aware of these allowable diagnoses to avoid any delays in payment.
9. **National Correct Coding Initiative (NCCI) edits applied to the claim:** Provider should submit a claim reconsideration only when disputing a payment denial, payment amount or a code edit. This includes NCCI edits. Provider should include documentation to show medical necessity. For additional information view the Authorization and Claim Reconsideration Guides available on our website, under the "Forms" tab on the Marketplace website and under the "Manual" tab on all other lines of business (LOB). These guides are specific to each LOB.

Attend our **September It Matters to Molina Training on the Claim and Prior Authorization Reconsideration Process** for additional assistance.

Provider Training Sessions

Information for all network providers

Monthly It Matters to Molina Provider Forum Topic:

- **September: Claim and Prior Authorization Reconsideration Process:** Wed., Sept. 30, 2 to 3 p.m. meeting number 133 297 7127, password jGSfJPrD452

Claim Reconsideration

Information for all network providers

BH providers are required to follow the claim reconsideration process for disputing how a claim was processed. Submit a claim reconsideration form only when disputing a payment denial, payment amount or code edit.

A Claim Reconsideration Request Form must be submitted for any dispute that is related to a claim denial that is not due to an authorization. An Authorization Reconsideration Form must be attached to any request involving an authorization denial or update.

The appropriate form will be required to process the reconsideration. These forms are available on our website under the "Forms" tab. Please be sure you are accessing the current version of the form on our website or your request will be returned unworked.

COVID-19 Updates

Information for all network providers

For COVID-19 information, visit our provider website and review the COVID-19 (Coronavirus) page located under the "Communications" tab.

Provider Enrollment in MITS

Information for all Community BH Center providers

As a reminder, ODM and the Ohio Department of Mental Health and Addiction Services (OhioMHAS) have discontinued the Universal Roster and moved forward with using one system, Medicaid Information Technology System (MITS), as the primary source of provider enrollment and affiliation information.

For additional information visit the ODM BH website and under "MITS Bits & Newsletters" select "Universal Roster Discontinuation and Move to Provider Master File Only, Effective Immediately."

It is imperative that CBHC providers update MITS with accurate information so that it is shared with all Managed Care Plans (MCPs) via the daily Provider Master File (PMF). There are several steps

Monthly Provider Portal Training:

- Tues., Sept. 15, 2 to 3 p.m. meeting number 133 618 9688, password U5BpeFM7mp3
- Thurs., Oct. 8, 10:30 to 11:30 a.m. meeting number 133 793 6084, password URuMpbcH356

Monthly Claim Submission Training:

- Thurs., Sept. 17, 11 a.m. to 12 p.m. meeting number 281 076 174, password sQ9vMmMPp89
- Mon., Oct. 12, 9 to 10 a.m. meeting number 133 791 3758, password fPggMBte342

Quarterly Provider Orientation:

- Tues., Nov. 24, 2 to 3 p.m. meeting number 133 091 0716, password vgDvDpZV426

To join WebEx, follow the instructions under "How to Join WebEx."

Changing a Service Location Address

Information for all network providers

Service locations are key to claim processing, so it is important that any changes to a service location address are submitted timely to Molina to avoid claim denials.

When updating a service location address the provider should complete the Provider Information Update Form available on the Molina website, under the "Forms" tab. Submission should include any appropriate attachments for specialists or primary care providers. The completed form can be emailed, mailed or faxed to Molina for processing.

Changing a Remittance Address

Information for all network providers

It is important for providers to update any changes to their remittance (Explanation of Payment [EOP]) address in order to avoid delays or misrouted payments. The remittance address is where all payments, letters and important notifications are sent.

When updating a remittance address the provider should complete the Provider Information Update Form available on the Molina website, under the "Forms" tab. Submission should include an updated W-9. The completed form can be emailed, mailed or faxed to Molina for processing.

CBHC providers should take in order to achieve the single system goal, including:

- View the ODM training presentation and webinar recordings for step-by-step instructions on how rendering practitioners can enroll in MITS, become affiliated with their employing agency and make changes to licenses, provider specialties and names.
- Review the online CBHC Practitioner Enrollment File for correct provider type, specialty and affiliation, and make any updates in MITS.

BH Cash Advance Repayments

Information for community BH providers in the Medicaid network

As a reminder, providers who suspended their payments should have resumed their agreed-upon repayment schedules and monthly payment amounts as of July 1, 2020.