2025 Provider Manual Annual Update Cycle
Significant Updates by Section/Chapter –
Medicaid Provider Manual

The items listed in this document outline content section-by-section where significant updates have been made to the Molina Healthcare of Ohio, Inc., Medicaid Provider Manual. Format changes, removal of redundant information and/or streamlining of language have been made throughout the document. Additionally, content has been added to the Provider Manual that has been previously communicated in Provider Manual Addendums and Provider Bulletins posted to the Molina Provider Website.

Material changes to content are called out in the information below:

Table of Contents

- Refreshed sections to align to changes in the Provider Manual.

II. Basic Plan Information

- Updated "Provider Services Department" to help differentiate between the Provider Services Department and the Provider Relations Department.
- Addition of "Provider Relations Department" section with services provided and contact information.
- Added clarification on authorization submission processes under the "Health Care Services" Department.

III. Provider Resources

- Updated "Provider Portal: Availity Essentials Portal" to include new Availity features to create, submit and track Claim Disputes (Reconsiderations).

IV. Provider Responsibilities

- Addition of an "Artificial Intelligence" section, including a definition of Artificial Intelligence (AI), as well as information on regulations, requirements and expectations on advanced communication to Molina if AI is used by the Provider that may impact the provision of Covered Services to Molina Members.
- Updated references in the "Cybersecurity Requirements" section from "the Provider Agreement" to "the Provider's Agreement with Molina."
- Updated the "Provider Data Accuracy and Validation" section to include information on enrollment prerequisites with ODM and Medicaid number requirements.

V. Provider Enrollment, Credentialing and Contracting

- Updated the "Provider Enrollment (ODM Functions)" section to reflect the 2024 registration fee.

- Updated the "Provider Maintenance" section to include additional details on Molina provider data change notification requirements for data elements Molina collects outside of the PNM system.

VI. Covered Services

- Clarified the pharmaceutical services covered by Molina, rather than the SPBM.
- Added "Injectable and Infusion Services" section for clarification on self-administered and office-administered products.
- Updated "Access to Behavioral Health Services" section with details, including a new phone number, on how to help a member who is not eligible for the OhioRISE plan receive behavioral health services through Molina.
- Updated the "Nurse Advice Line" to note the Nurse Advice Line handles urgent and emergent after-hours utilization management calls.
- Updated the "Vision Services," "Transportation," "Incentives to Strengthen Health & Well-Being" and "Application or Online Services" sections in the Value-Added Benefits for Members grid with new details on member benefits for 2025.
- Updated the "Referrals" section with additional information on when prior authorization is required for a referral and how to arrange specialty care outside the network.
- Updated the "Access to Behavioral Health Providers and PCPs" section to note that individual services provided by non-network behavioral health providers will require prior authorization.
- Clarified definition of Emergency Medical Condition and added the definition for Emergency Services in the "Emergency Services" section.
- Added a subsection called "Well-Child/Adolescent Visits" to the "Well Child Visits and EPSDT Guidelines" section. Content updated to help define when additional evaluation and testing is required.
- Updated the "Unlisted Codes" section noting providers are encouraged to request PA and to bill with the most accurate and specific code when available.
- Added OAC 5160-3-15.1 information to the "Nursing Facilities (NF)" section, providing information on preadmission screening requirements for individuals seeking admission to nursing facilities.

VII. Utilization Management

- Updated the "Behavioral Health Utilization Management and Prior Authorization" section to include prior authorization requirements for a member's consecutive days of admission beyond 30 days.

- Added new language on "Inpatient Admission Policy" and Jan. 1, 2025 change in process.
- Updated the "Utilization Management Decisions" section with a more detailed definition of expedited/urgent care for purposes of service request designation.
- Updated the "MCG Cite Guideline Transparency" section with new Cite AutoAuth services and how to access Cite AutoAuth.
- Added a new "What is Cite AutoAuth and How Does it Work?" section with information on Cite AuthoAuth functionality and services available.

VIII. Claims Information

- Updated the "Electronic Visit Verification (EVV)" section to direct providers to ODM's EVV Homepage.
- Updated the "Required Elements on Claims" language with additional National Drug Code (NDC) and unit requirements, as well as data validation information.
- Added additional submission details on corrected claims in the "3. Corrected Claim Process" section.
- Updated the "Directions on how to correct or void a Claim" section with new details on where to locate training.
- Updated the "4. Coordination of Benefits (COB)" section with information on third party liability and subrogation.
- Updated the "Provider Takes Reasonable Measure to Obtain Third Party Payment" to direct providers to OAC 5160-26-09.1 to define the reasonable measures required.
- Updated language in the "Balance Billing" section with information from OAC 5160-1-13.1 on the conditions that must be met for balance billing.
- Changed the "Process and Requirements for Appeal of Denied Claims (Provider Claims Dispute Process)" name to "Process and Requirements for Appeal of Denied Claims (Provider Claims Dispute Resolution Process)"
- Updated the "Non-Clinical Claim Disputes (not related to an Authorization/ Medical Necessity Review)" section to include appeals.

IX. Care Coordination/Care Management

- Changed the name "Intensive Care Management (ICM)" to "Complex Care Management (CCM)" in the chapter.
- Updated the phone number for referrals to the CCM program.
- Updated the phone number for referrals to the health management programs.

- Removed faxing as an option for how providers can notify Molina of new pregnant members in the "Maternity Screening and High-Risk Obstetrics" section.
- Updated the "D. What is the Coordinated Services Program (CSP)" section to better define the scope of CSP.

X. Reporting

- No significant changes.

XI. Next Generation Managed Care Program

- Updated the "A. OhioRISE" section to better define the program's goals.

XII. Member Enrollment, Eligibility, Disenrollment

- Updated Member Cards to align to 2025 programs.

XIII. Quality

- No significant changes.

XIV. Compliance

- Updated 45 CFR 154.501 to 45 CFR 164.501 in "Post-Payment Recovery Activities" section and added a hyperlink.

XV. Members' Rights and Responsibilities

- No significant changes.

XVI. Pharmacy

- Added a new "B. Carved Out Drugs" section to clarify which drugs are carved out from the Managed Care Organization coverage.

XVII. Risk Adjustment Management Program

- Added Epic Payer Platform as an automated method for delivering relevant clinical documents to Molina in the "Interoperability" section.

XVIII. Delegation

- No significant changes.