MOLINA® HEALTHCARE

Third quarter 2023

# Provider Newsletter

FOR MOLINA HEALTHCARE PROVIDERS

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The provider newsletter is available to all network providers serving Molina Healthcare members.

# Availity Essentials is Molina Healthcare's exclusive provider portal

Availity Essentials is Molina Healthcare's official secure provider portal for traditional (non-atypical) providers (i.e., personal care, adult day care, taxi services, or home modifications). Some of the core features available in Essentials for Molina include eligibility & benefits, attachments, claim status, Smart Claims and Payer Space (submit and check prior authorizations as well as appeal status and appeal/dispute).

Several new features and enhancements have recently been added to Essentials for Molina providers. In case you missed it, check out the latest enhancements that were designed to simplify your workflows and reduce administrative burden:

| What's New | How does it benefit me? |
|---|---|
| **Claims corrections** | Molina providers now have access to a new claims correction feature from the claim status page. Claims correction allows you to correct and resubmit a paid or denied claim from the claim status response page. |
| **Overpayments** | Eliminate mail and fax for faster dispute resolution and ensure overpayment requests are up to date. View the status and details of any claim Molina has identified as an overpayment. Request additional information, dispute or resolve the overpayment. |
| **Patient search** | Save time entering patient information for eligibility and benefits inquiries. Enter the patient's member ID or last name, first name and DOB, and select the patient matching the criteria. The information will automatically populate on the request. |
| **Molina Medicare now included in Molina Healthcare Payer Option** | Select only one option in the payer field. The Molina Medicare option no longer displays in the payer field. When you select the Molina Healthcare option for the region, the plan coverage for the member includes Dual-Eligible, Marketplace, Medicare and Medicaid. |

## Not registered with Availity Essentials?

If your organization is not yet registered for Availity Essentials and you're responsible for the registration, please visit **Provider.MolinaHealthcare.com** and click the **Register** button.

For registration issues, call Availity Client Services at **(800) AVAILITY (282-4548)**. Assistance is available Monday-Friday 8 a.m. to 8 p.m. ET.

### Dive deeper into Essentials

Once you have your Availity Essentials account, you can learn more about the features and functionality offered for Molina providers. Simply log in > go to **Help & Training > Get Trained** to register for a webinar.



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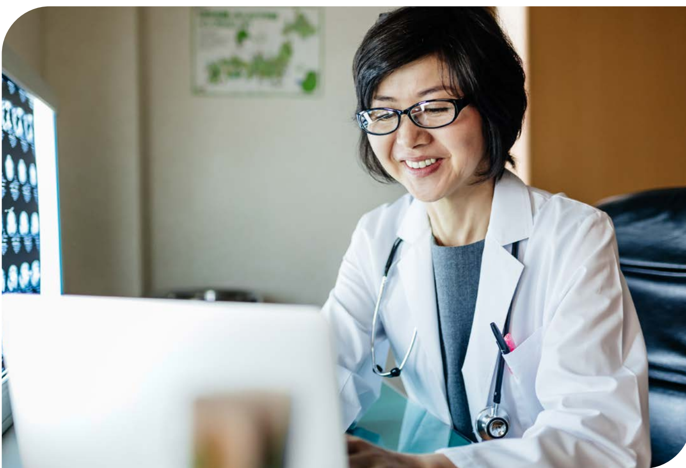
## Medicare Post-Acute Care clinical request form now available

The Medicare Post-Acute Care (PAC) clinical request form has been developed for providers requesting PAC for Molina Healthcare Medicare members. Molina strongly encourages providers to complete and submit this form for all post-acute patients – including acute inpatient rehab (AIR) – long-term acute care hospitals and sub-acute skilled nursing facilities (SNFs). The form was designed to capture vital discharge planning information to help reduce avoidable readmissions. All Medicare providers, MMP, FIDE, DSNP, MAPD, etc., should use this form for a PAC request.

Please visit the Medicare website under the **skilled nursing facility** tab.



## 2023 Molina Healthcare Model of Care provider training

In alignment with requirements from the Centers for Medicaid & Medicare Services (CMS), Molina Healthcare requires primary care providers (PCPs) and key high-volume specialists including Cardiology (and sub-specialties), Hematology/Oncology, and Psychiatry to receive training about Molina's Special Needs Plans (SNP) Model of Care (MOC).

The SNP MOC is the plan for delivering coordinated care and care management to special needs members. Per CMS requirements, managed care organizations (MCOs) are responsible for conducting their own MOC training, which means you may be asked to complete separate trainings by multiple insurers.

MOC training materials and attestation forms are available at **MolinaHealthcare.com/model-of-care-Provider-Training**.

The completion date for this year's training is December 31. 2023..

If you have any additional questions, please contact your local Molina provider services representative at: **(800) 424-4518** or **MCCVA-Provider@molinahealthcare.com.**



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## Enhanced Behavioral Health Toolkit for Providers now available

To support providers in offering best practice behavioral health interventions in the primary care setting, the Behavioral Health (BH) Toolkit for Providers has been updated on the Molina Healthcare Medicaid provider public website. Our BH Toolkit for providers highlights common conditions that may present in the primary care setting, including recommended standardized screening and assessment tools, interventions and resources.

The enhanced BH Toolkit includes newly added conditions for consideration and updated resources to support the delivery of best practices and standards of care to this population.

Some of the updates include:

1. **New!** Addition of the Maternal Mental Health Chapter.
2. **New!** Addition of the PsychHub access link, information and applicable/supporting PsychHub training opportunities associated with each chapter/topic (on each page).
3. **Updated:** External resources, population statistics and an overall refresh of clinical standard practices and recommendations.

To access the BH Toolkit for Providers, please visit your state's Molina Medicaid website and click **I am a Healthcare Professional**. You will find the Behavioral Health Toolkit under the **Health Resources** tab, or click **here** to be taken directly to the BH Toolkit for Providers page.

## Important Message – Updating provider information

It is important for Molina to keep our provider network information current. Up to date provider information allows Molina to accurately generate provider directories, process claims, and communicate with our network of providers. Providers must notify Molina of any changes, as soon as possible, but at a minimum 30 calendar days in advance of any changes in any Provider information on file with Molina. Changes include, but are not limited to:

- Change in office location(s)/address, office hours, phone, fax, or email.
- Addition or closure of office location(s).
- Addition of a Provider (within an existing clinic/practice)
- Change in Provider or practice name, Tax ID and/or National Provider Identifier (NPI).
- **Primary Care Providers (PCP) Only**: If your practice opens or closes to new patients
- Change in specialty.
- Any other information that may impact Member access to care.

Providers can make updates through the **CAQH portal**, or you may submit a full roster that includes the required information above for each health care Provider and/or health care facility in your practice. Providers unable to make updates through the **CAQH portal**, changes should be submitted on the Provider Information Update Form located on the Molina website at **MolinaHealthcare.com** located in the Provider Forms area.

Send changes by email to: **MCCVA-Provider@MolinaHealthcare.com** or by fax to **(888) 656-5098.**

Contact your Provider Services Representative at **(800) 424-4518** if you have any questions.



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## Practitioner Credentialing Rights: What you need to know

Molina must 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 provider, includes full disclosure of all issues and timely submission of all credentialing and re-credentialing information.

Molina also has a responsibility to its providers to assure the credentialing information it reviews is complete and accurate. As a Molina 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, except for 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
- Receive notification of the credentialing decision within 60 days of the committee decision or shorter timeframes as contractually required
- 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 provider, please review your provider manual. You may review the provider manual on our website at **MolinaHealthcare.com** or contact your Provider Services Representative at **MCCVA-Provider@molinahealthcare.com** or **(800) 424-4518** for more details.

# Molina's Utilization Management

One of the goals of Molina's Utilization Management (UM) department is to render appropriate UM decisions consistent with objective clinical evidence. To achieve this goal, Molina 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, and home environment, when applicable) and the local delivery system into account when determining the medical appropriateness of requested health care services.
- Molina's clinical criteria include MCG criteria that are utilized to conduct inpatient review (except when Change Healthcare InterQual® is contractually required); American Society of Addiction Medicine (ASAM) Criteria; National Comprehensive Cancer Network (NCCN); Hayes Directory; applicable Medicaid Guidelines; Molina Clinical Policy (MCP) and Molina Clinical Review (MCR) (developed by designated Corporate Medical Affairs staff in conjunction with Molina physicians serving on the Medical Coverage Guidance Committee); UpToDate; and other nationally recognized criteria including technology assessments and well controlled studies that meet industry standards and Molina policy; and when appropriate, third party (outside) board-certified physician reviewers.
- Molina ensures all criteria used for UM decision-making are available to practitioners upon request. The clinical policy website, **MolinaClinicalPolicy.com** provides access to MCP and MCR criteria. Providers also have access to the MCG Cite for Care Guideline Transparency tool through our **Availity Essentials Portal**. To obtain a copy of the UM criteria used in the decision-making process, call our UM Department at **(800) 424-4461.**
- As the requesting practitioner, you will receive written notification of all UM denial decisions. If you need assistance contacting a medical reviewer about a case, please call the UM Department at **(800) 424-4461.**

It is important to remember:

- UM decision-making is based only on the appropriateness of care and service and the existence of coverage.
- Molina does not specifically reward practitioners or other individuals for issuing denials of coverage or care.
- UM decision-makers do not receive financial incentives or other types of compensation to encourage decisions that result in underutilization.
- Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage.
- Medicaid members have the right to a second opinion from a qualified practitioner. If an appropriate practitioner is not available in-network Molina will arrange for a member to

obtain a second opinion out of network at no additional cost to the member than if the services were obtained in-network. Molina provides for a second opinion from a qualified in-network practitioner. Members from all Molina lines of business and programs should refer to their benefit documents (such as Schedule of Benefits and/or Evidence of Coverage) for second opinion coverage benefit details, limitations, and cost-share information. If an appropriate practitioner is not available in-network, prior authorization is required to obtain the second opinion of an out of network provider. Claims for out of network providers that do not have a prior authorization will be denied, unless regulation dictates otherwise. All diagnostic testing, consultations, treatment, and/or surgical procedures must be a benefit under the plan and meet all applicable medical necessity criteria to be covered.

- 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

Molina'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 **(800) 424-4461.** You may also fax a question about an UM issue to Molina The Medical Director is available for more complex medical decision questions and explanations of medical necessity denials.

Molina offers the ability to quickly and conveniently submit and status check prior authorization (PA) through our provider portal, available at: **Availity Essentials Portal**.

**Molina PA fax numbers include:**

- Advanced Imaging: **(877) 731-7218**
- Medicaid: Inpatient Physical Health - **866-210-1523**
- Medicaid Outpatient Physical Health - 855-769-2116
- Medicaid Long Term Support Services (LTSS) - **800-614-8207**
- Medicaid Behavioral Health - **855-339-8179**
- Medicaid Care Coordination Documents (Newborn notification, UAI, IFSP, etc.) -**800-614-7934**
- Medicaid Transplant - **877-813-1206**
- Medicaid Maternity - **(866) 210-1523**

For information about Molina's formulary PA and the exception process, please refer to the *Drug Formulary and Pharmaceutical Procedures* article.

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

# Drug Formulary and pharmaceutical procedures

At Molina, the Drug Formulary (sometimes referred to as a Preferred Drug List or PDL) and pharmaceutical procedures are maintained by the National Pharmacy and Therapeutics (P&T) Committee. This committee meets on a quarterly basis or more frequently, if needed.

The National Pharmacy and Therapeutics (P&T) Committee is responsible for development and updating drug formularies that promote safety, effectiveness, and affordability, where state regulations allow. The committee objectively reviews new Food and Drug Administration (FDA) approved drugs, drug classes, new clinical indications for existing drugs, new line extensions and generics, new safety information and also new clinical guidelines and practice trends that may impact previous formulary placement decisions. Additional committee oversight includes prior authorization, step therapy, quantity limits, generic substitutions, medical exception protocols to allow coverage for non-formulary drugs, other drug utilization management activities that affect access, and providing drug utilization evaluations and intervention recommendations to Molina Health Plans. Drug formulary activities are inclusive of prescriber-administered specialty medications as a medical benefit as well as pharmacy benefit services.

The drug formularies reviewed and approved by the P&T committee are updated quarterly and include an explanation of quantity limits, age restrictions, therapeutic class preferences, and step therapy protocols. These changes and all current documents are also posted on the Molina website under the Drug Formulary tab.

Providers may request a formulary exception for coverage of a drug outside of the restrictions of the drug formulary. A formulary exception should be requested to obtain a drug that is not included on a member's drug formulary, or to request to have a utilization management requirement waived (e.g., step therapy, PA, quantity limit) for a formulary drug. Select medications on the drug formulary or drugs not listed on the formulary may require PA. PA is a requirement that a prescriber obtains advance approval from Molina before a specific drug is delivered to the member to qualify for payment coverage, sometimes called precertification or prior approval. The Drug Formulary/PDL is available online at **MolinaHealthcare.com** under the tab called Drug Formulary.

The National Pharmacy and Therapeutics (P&T) Committee is also responsible for promoting member safety. In the event of a Class II recall or voluntary drug withdrawal from the market for safety reasons, affected members and prescribing practitioners are notified by Molina within 30 calendar days of the FDA 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.

## Case Management

Molina 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 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 they are provided at the appropriate level of care in a timely manner
- Provide a comprehensive and ongoing 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 **(800) 424-4518**..

## Resources available on Molina's provider website

Featured at **MolinaHealthcare.com**:

- Clinical Practice and Preventive Health Guidelines
- Quality Improvement Programs
- Member Rights & Responsibilities
- Privacy Notices
- Provider Manual
- Current Formulary
- Cultural Competency Provider Trainings

If you would like to receive any of the information posted on our website in hard copy, please call **(800) 424-4518.**

## 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 at **(800) 424-4518.** 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 members in collaboration with their primary care providers.

### Safe Clinical Practice

The Molina 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 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 (**leapfroggroup.org**)
- The Joint Commission Quality Check® (**qualitycheck.org**)

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

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

## Hours of operation

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


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## Non-discrimination

All providers who join the Molina provider network must comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS), the Office for Civil Rights (OCR), State law, and Federal program rules which prohibit discrimination. For additional information please refer to:

Medicaid: CCC Plus Member Handbook located at: https://www.molinahealthcare.com/members/va/en-us/mem/medicaid/member-materials-and-forms.aspx.

Medicaid: Medallion 4.0 Member Handbook located at: https://www.molinahealthcare.com/members/va/en-us/mem/medicaid/member-materials-and-forms.aspx.

Additionally, participating providers or contracted medical groups/IPAs may not limit their practices because of a member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.

## Member rights and responsibilities

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

### Molina members have the right to:

- Receive information about Molina, 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
- Voice complaints or appeals about Molina or the care it provides
- Make recommendations regarding Molina member rights and responsibilities policy

### Molina members have the responsibility to:

- Supply information (to the extent possible) that Molina and its practitioners and providers need 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 Member Rights and Responsibilities Statement for your state on our website, **MolinaHealthcare.com**. Written copies and more information can be obtained by contacting the Provider Services Department at **(800) 424-4518** or **MCCVA-Provider@molinahealthcare.com.**

# Population Health

## (Health education, disease management, care management, and complex case management)

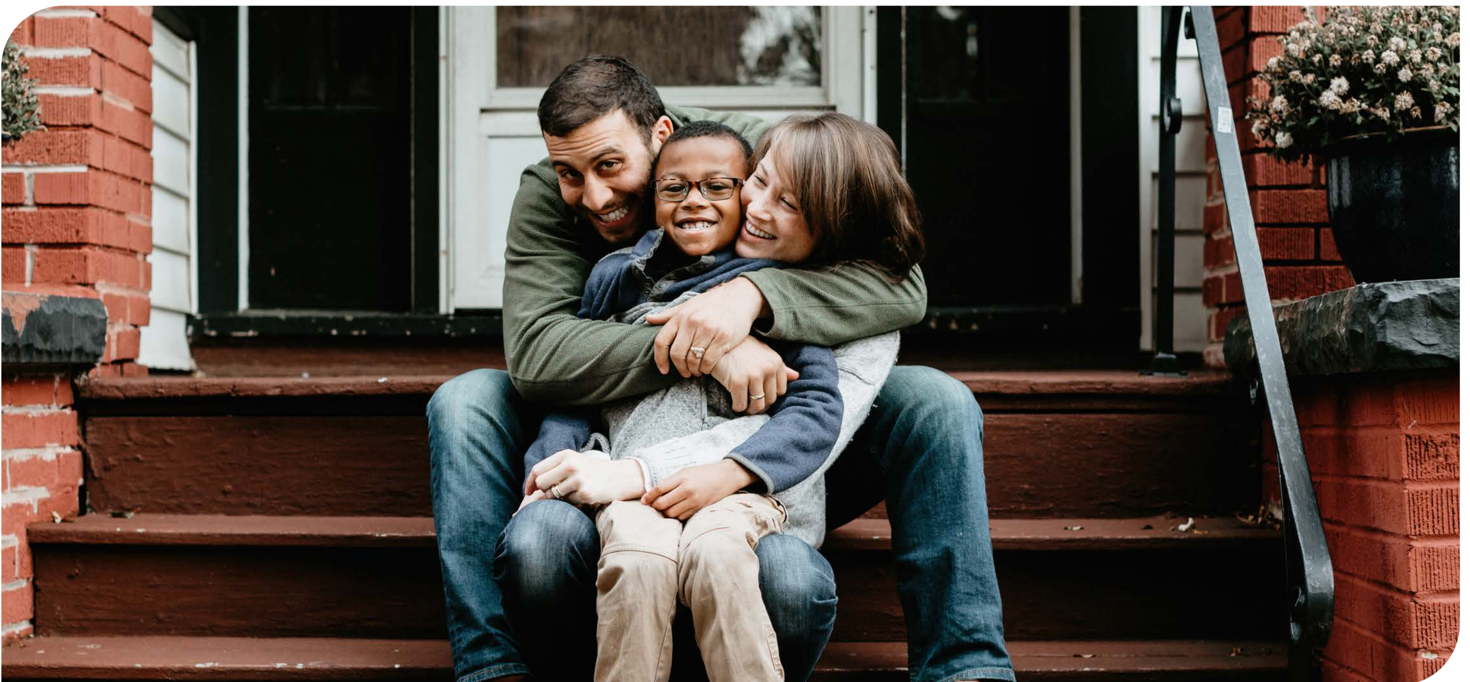
The tools and services described here are educational support for our members. We may change them at any time as necessary to meet the needs of our members.

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
- High-Risk Obstetrician-Gynecologists (OB-GYN) Case management
- Transition of Care (ToC)

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

If you have additional question about our programs, please call: Provider Services Department at **(800) 424-4518** (TTY/TDD: **711**).





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# Quality Improvement Program

Molina's Quality Improvement Program 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 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 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
- Confirmation of the quality and adequacy of the provider and Health Delivery Organization network through appropriate contracting and credentialing processes

The Quality Improvement Program promotes and fosters accountability of employees, network, and affiliated health personnel for the quality and safety of care and services provided to Molina members.

The effectiveness of Quality Improvement Program 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 Quality work plan quarterly
- Revising interventions based on analysis, when indicated
- Evaluating member satisfaction with their experience of care through the Consumer Assessment of Healthcare Providers and Systems (CAHPS® ) survey
- Reviewing member satisfaction with their experience with behavioral health services through survey questions and/or evaluation of behavioral health-specific complaints 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 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 website, please contact the Quality Improvement Department at QualityVA@MolinaHealthcare.com.

If you would like more information about our Quality Improvement Program or initiatives and the progress toward meeting quality goals you can visit our website at MolinaHealthcare.com and access the Health Resources area located on our provider website pages to obtain more information. If you would like to request a paper copy of our documents, please contact the Quality Department at QualityVA@MolinaHealthcare.com.

## Standards for medical record documentation

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

Molina'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 Department at QualityVA@MolinaHealthcare.com.

## Preventive Health Guidelines

Preventive Health Guidelines can be beneficial to providers and their 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.

You can also view all guidelines at MolinaHealthcare.com by accessing the Health Resources section within our provider webpages. To request printed copies of Preventive Health Guidelines, please contact Provider Services at **(800) 424-4518**.

# 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 care recommendations 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 has adopted the following Clinical Practice and Behavioral Health Guidelines, which include but are not limited to:

- Acute Stress and Post-Traumatic Stress Disorder (PTSD)
- Anxiety/Panic Disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism
- Bipolar Disorder
- Children with Special Health Care Needs
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Heart Failure in Adults
- Homelessness - Special Health Care Needs
- Hypertension
- Obesity
- Opioid Management
- Perinatal Care
- Pregnancy Management
- Schizophrenia
- Sickle Cell Disease
- Substance Abuse Treatment
- Suicide Risk
- Trauma-Informed Primary Care

You can also view all guidelines at **MolinaHealthcare.com**, in the Health Resources section of the provider webpages. To request a copy of any guideline, please contact Molina's Provider Services Department at **(800) 424-4518.**



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## Advance Directives

Helping your patients prepare for 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 and information to help create an Advance Directive:

- **caringinfo.org**
- **nlm.nih.gov/medlineplus/advancedirectives.html**

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 advance care planning is a part of good health care.

## Behavioral Health

Primary care providers (PCPs) provide outpatient behavioral health services within the scope of their practice and are responsible for coordinating members' physical and behavioral health care.

Behavioral Health services are a direct access benefit and are available with no referral required; however, PCPs are responsible for assisting in coordinating a referral if needed. If you or the member need assistance with obtaining behavioral health services, please contact Member Services Department at **(800) 424-4518.** Molina's Nurse Advice Line is also available to members 24 hours a day, seven days a week, 365 days per year for mental health or substance abuse needs. The services Members receive will be confidential.

Providers may refer to the Molina Behavioral Health Toolkit for Providers on the **MolinaHealthcare.com** public website for additional clinical guidance, recommendations, and trainings/education opportunities related to behavioral health conditions. Providers can locate the Behavioral Health Toolkit for Providers under the Health Resources tab at **MolinaHealthcare.com**.

# Care coordination & transitions

### Coordination of care during planned and unplanned transitions for Molina members

Molina is dedicated to providing quality care for our members during planned or unplanned transitions. A transition is when members move from one setting to another, such as when a Molina member is discharged from a hospital. By working together with providers, Molina makes a special effort to coordinate care during transitions. This coordination of specific aspects of the member's transition is performed to avoid potential adverse outcomes.

To ease the challenge of coordinating patient care, Molina has resources to assist you. Our staff, including nurses, are available to work with all parties to ensure appropriate care.

To appropriately coordinate care, Molina will need the following information in writing from the facility within one business day of the transition from one setting to another:

- Discharge plan when the member is transferred to another setting
- A copy of the member's discharge instructions when discharged to home

**This information should be faxed to Molina at:**

- UM Department:: **(800 424-4461**
- Member Services: **(800) 424-4518**

# Health Risk Assessment and self-management tools

Molina provides a Health Risk Assessment (Health Appraisal) for members on the My Molina member portal. Our members are asked questions about their health and health behaviors and receive a report about possible health risks. A Self-Management Tool is also available to offer guidance for weight management, depression, financial wellness, and various other topics. Molina members can access these tools on **MyMolina.com**.

# Healthcare services for members of the Tribal community

As a healthcare professional, it is important to be aware that some of your patients may be part of an American Indian Tribe. It is important to respect their cultural identity and traditions while ensuring that they receive proper medical care. American Indian Tribe members have a right to access services from Tribal Health Clinics/Providers.* Medication prescriptions and referrals from Tribal providers must be honored in the same manner as in-network providers. This is to ensure that members receive the same quality of care regardless of the provider they choose to see.

State-recognized Tribal Health Clinics/Providers such as Aylett Family Wellness and Fishing Point Healthcare offer covered Medicaid services, without a referral.

### Questions?

If you have any questions as it pertains to Tribal Health Clinic/Providers and covered benefits, please contact a Molina Provider Service Representative at MCCVA-Provider@molinahealthcare.com.



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# Clinical policy update highlights from second quarter 2023

Molina Clinical Policies (MCPs) are located at **MolinaClinicalPolicy.com**. The policies are used by providers, medical directors and internal reviewers to make medical necessity determinations. MCPs are reviewed annually and approved bimonthly by the Molina Clinical Policy Committee (MCPC).

### The following new policies were approved:

- MCP-432: Developmental Testing
- MCP-700: Foot Surgery: Bunionectomy
- MCP-701: Foot Surgery: Hallux Rigidus
- MCP-702: Foot Surgery: Lesser Toe Deformities (Hammer, Mallet, and Claw Toe)
- MCP-434: Non-Emergent Air Ambulance Transport
- MCP-430: Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy (NeuroPace®)
- MCP-431: Sclerotherapy

### The following new policies were approved:

- **MCP-067: Back Braces**
  - Revision to coverage limitations and exclusions to remove "Management of preoperative or postoperative spinal fusion surgery" and "Treatment of spinal burst fractures with or without neurological deficits."
- **MCP-204: Blepharoplasty**
  - Policy reviewed, added clarification that visual field testing is not necessary for children ages 12 and under (for upper eyelid blepharoptosis repair).
- **MCP-315: Breast Implant Removal**
  - Policy reviewed, included indication for BIA-SCC, updated Summary of Medical Evidence section.
- **MCP-041: Cranial Orthotic Devices**
  - Revision to criteria #3a from "> 10-12mm" to ">12mm" to remove ambiguity.
- **MCP-051: Genetic Testing**
  - Policy reviewed, clarified hierarchy of policy utilization, change in coverage requirements to allow practitioners within their scope practice and to allow 2 published studies (vs. 3) to establish phenotype/genotypic alignment. Clarification of verbiage and coding.
- **MCP-050: Hyperbaric Oxygen Therapy and Topical Oxygen Therapy**
  - Coverage criteria updated to include initial authorization of up to 20 sessions with prior authorization being required for additional sessions. Updated Overview, Summary of Medical Evidence, and References.
- **MCP-409: Occupational Therapy**
  - Criteria wording updated for clarification and included information regarding re-evaluations, discharge and discontinuation of therapy.



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- **MCP-402: Plantar Fasciitis Surgery**
  - Revised coverage criteria #3 from “exclude” to “include” and added note on heel spurs.
  - Updated Overview, Summary of Medical Evidence, Coding & Billing, and References.
- **MCP-412: Prescription Digital Therapeutics**
  - Added RelieVRx, the first VR device designated as an DME and HCPCS Level II code E1905 (Virtual reality cognitive behavior therapy device [CBT], including pre-programmed therapy software).
- **MCP-357: Skin Substitutes**
  - Previously named “Skin Substitutes for Chronic Wound Healing Outpatient.” Removed “for chronic wounds” as chronicity does not apply to burn wounds.
  - Removed line of business-specific criteria.
  - Removed criteria requiring failed standard treatment for burn wounds.
  - Duration of failed treatment required prior to EpiFix updated to four weeks.
  - Updated to clarify EpiFix in sheet form is covered when criteria are met.

**The following policies have been retired and are no longer available on the website:**

- **MCP-401: Foot Surgery Guidelines for Deformities of the Toes (Bunion, Hammertoe, Hallux Rigidus)**
  - Retired – procedures separated into new MCPs 700, 701, 702.
- **MCP-295: High-Intensity Focused Ultrasound for Prostate Cancer**
  - Retired in lieu of MCG criteria; ACG: A-0271 (AC). Same I/E position as MCP.
- **MCP-364a: COVID-19 Copays and Cost Share (Marketplace)**
- **MCP-364b: COVID-19 Copays and Cost Share (Medicaid)**
- **MCP-364c: COVID-19 Copays and Cost Share (Medicare)**
  - Retired due to the expiration of the public health emergency – effective May 11, 2023.

## Provider Manual updates

The Provider Manual is customarily updated annually but may be updated more frequently as needed. Providers can access the most current Provider Manual at https://www.molinahealthcare.com/providers/va/medicaid/resources/provider-materials.aspx.

## Reminder: Provider Information and Education for Implementing Coding Validation

As a valued member of our provider community, we want to inform you about some upcoming enhancements to claims processing. We will be adding new edits that address coding situations that are too complex to auto adjudicate and accordingly have a human review component.  The edits are based correct coding rules, published by national industry sources and administrative bodies, to detect potential coding errors and incorrect billing practices.

One issue addressed by the new edits are the correct use of modifiers.  Modifiers have been defined by the American Medical Association (AMA) and adopted by Centers for Medicare and Medicaid (CMS), to provide additional information about the services that were rendered.  The National Correct Coding Initiative (NCCI) Policy Manual provides directions on when modifiers should be used.  It states "Modifiers may be appended to HCPSC/CPT codes only if the clinical circumstances justify the use of the modifier.  A modifier shall not be appended to a HCPCS/CPT solely to bypass an NCCI PTP edit if the clinical circumstances do not justify its use."  NCCI Policy Manual, January 2019.  The new edits involve the review of the information on the claim and in the patient's claim history to determine if the modifier has been used correctly.  Modifiers 25, 59, XE, XS, XP and XU are among the most commonly used modifiers, therefore, the new edits will be evaluating the correct use of these and other overriding modifiers.  To prevent the incorrect processing of claims we are providing information about when these modifiers should be used.

CPT and the AMA specify that by using a modifier -25 the provider is indicating that a "significant, separately identifiable evaluation and management service (was provided) by the same physician on the same day of the procedure or other service".  CPT guidelines also state that this significant and separate service must be "above and beyond" the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.  The AMA Guidelines in "Coding with Modifiers" state that "The E/M service must meet the key components (i.e., history, examination, medical decision making) of that E/M service including medical record documentation. … To use modifier 25 correctly, the chosen level of E/M service needs to be supported by adequate documentation for the appropriate level of service, as well as referenced by a diagnosis code. … The CPT codes for procedures do include the evaluation services necessary before the performance of the procedure (e.g., assessing the site and condition of the problem area, explaining the procedure, obtaining informed consent); however, when significant and identifiable (i.e., medical decision making and another key component) E/M services are performed, these services are not included in the descriptor for the procedure or service performed."



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Modifiers 59, XE, XP, XS, XU should be used when the physician needs to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician.

When preparing claims for submission it is important to make sure that all the appropriate diagnosis codes are assigned to the claim and that modifiers are used only when clinically appropriate based on published guidelines. If you have claims that you believe are incorrectly denied due to the incorrect use of modifiers, please submit medical records so that we can determine the correct payment for those claims. Additional information about when to use modifiers can be found in the CPT manual, in the Provider and NCCI manuals found on CMS's website.


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