February 8, 2016

Provider Memorandum

Hospital Fee-For-Service Billing Guidelines

Effective immediately, Molina Healthcare of Illinois (Molina) is implementing a revised billing guidelines for hospitals billing for fee-for-service procedures using the fee-for-service registered Medicaid ID correlating to the applicable categories of service (COS). Hospitals eligible to render these covered services to Medicaid beneficiaries must follow prescribed billing criteria in order to be reimbursed correctly from Molina.

The Illinois Department of Healthcare and Family Services (HFS) requires Molina meet specific claims data submission standards requiring particular and exact data elements on claims submitted from hospitals. The mandate is as follows:

- Hospital Providers are required to adhere to specific HFS formatting guidelines for Managed Care Organizations (MCOs) related to claims submission for ancillary services.
- HFS requires that outpatient services are submitted via an UB-04 form (837I) to include one of the following:
    - Ambulatory Procedure Listing (APL) procedure code
    - Emergency room revenue code
    - Operating room revenue code

In all cases where one or more of these three criteria is not met, hospital Providers are required to submit claims via a CMS-1500 form (837P). Molina will reject these types of claims if the protocol is not followed.

Hospitals are able to submit fee-for-service claims when enrolled as the following Provider Types:

- 30 – General Hospital
- 31 – Psychiatric Hospital
- 32 – Rehabilitation Hospital

Fee-for-service billable under Hospital's Name and National Provider Identifier (NPI):

Hospitals are allowed to bill directly on a fee-for-service basis for the following COS:

- 001 Physician Services
- 011 Physical Therapy Services
- 012 Occupational Therapy Services
- 013 Speech Therapy/Pathology Services
- 014 Audiology Services
- 017 Anesthesia Services
- 030 Healthy Kids Services
- 040 Pharmacy Services (Legend and OTC)
- 041 Medical Equipment /Prosthetic Devices
- 048 Medical Supplies

The COS are limited to the following procedures:

- Administration of chemotherapy for the treatment of cancer
- Administration and supply of the following injectable medications:
    - Chemotherapy agents for the treatment of cancer
    - Non-chemotherapy drugs administered for conditions associated with the chemotherapy and submitted with the cancer-related diagnosis
    - Baclofen
    - Lupron
    - RhoGAM
    - Tysabri

- Reference (outside) laboratory services
- Outpatient laboratory and radiology services ordered by a physician
- Durable Medical Equipment and Supplies
- Physical, Speech and Occupational therapy

Claims must be billed under the hospital's name and NPI:

- Payment for these services will be based on the same fee schedule and billable codes that applies to these services when they are provided in a non-hospital setting
- Payment rates for the fee-for-service billable physical therapy remain the same as they were under the APL, as of June 30, 2012
- Hospitals may bill fee-for-service for the administration of chemotherapy in a hospital outpatient setting. Hospitals may bill fee-for-service for chemotherapy drugs even if no administration fee is billed. Drugs used in the administration of the chemotherapy should not be billed through the Pharmacy Program
- Hospitals billing for appropriate drugs include the following requirements:
    - Submit claims using the correct eleven-digit National Drug Code (NDC) number following the HCPCS code.

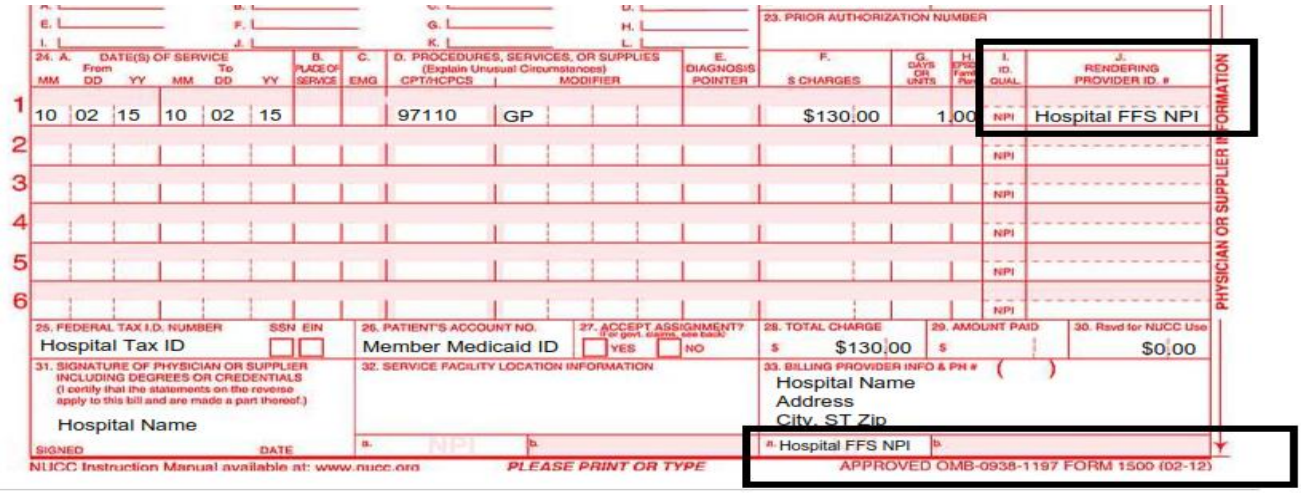
Fee-For-Service Claims Not billable under Hospital's Name and NPI

Hospitals may not bill fee-for-service under the facility name and NPI for the professional services of salaried physicians and Advanced Practice Nurses in an outpatient setting. These claims for professional services must be billed under the name and NPI of the practitioner who rendered services. **These claims must be billed under the salaried physician's name and NPI**.

A salaried physician means:

- A physician salaried by the hospital
- Physicians salaried by the hospital do not include radiologists, pathologists, nurse practitioners, or certified registered nurse anesthetists. No separate reimbursement will be allowed for such Providers
- A physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care
- A group of physicians with a financial contract to provide emergency department care

As an example, a hospital billing a CPT code 97110 for physical therapy should use the hospital fee-for-service NPI associated with the registered Medicaid ID that correlates to COS 011. The information must be provided to Molina in order to be accepted appropriately in all the boxes as depicted below:



Hospital Special Enrollment as a Pharmacy

Hospitals are able to submit fee-for-service claims when enrolled as the following Provider type:

60 – Pharmacy

A hospital pharmacy is able to bill on a fee-for-service basis for services provided to a patient in:

- A specified bed or special hospital unit which is certified for skilled nursing facility services under the Medicare Program
- A special hospital unit or separate facility which is administratively associated with the hospital and is licensed as a long term care facility
- An outpatient setting where services provided are not unique to the hospital setting (are not hospital APL-billable)